STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

THURSDAY, MARCH 24, 2022

9:00 A.M.

Reported by: John Cota

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APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Bill Barcellona

Dannie Ceseña

Alex Chen

Cheryl Damberg

Diana Douglas

Lishaun Francis

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Richard Riggs

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen

Stesha Hodges

Robyn Strong

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Anna Wright, Equity Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME, JD

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Nancy Kohler, Quality SME

Janel Myers, Quality SME

Others Presenting/Commenting

Rachel Harrington
National Committee for Quality Assurance (NCQA)

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PROCEEDINGS

9:00 a.m.

MS. BROOKS: Good morning, everyone, and welcome to the second Department of Managed Health Care Health Equity and Quality Committee. My name is Sarah Brooks; I am a consultant with Sellers Dorsey, a consulting firm that has been engaged by the Department of Managed Health Care to support this effort.

AB 133, the budget bill from last year, charges the Committee with making recommendations to the DMHC specifically on health equity and quality measures and benchmarks that should be utilized for oversight of managed care plans overseen by the DMHC. These recommendations will be made and put forth to the DMHC in the form of a report developed by Sellers Dorsey and representative of the Committee's positioning.

A meeting summary of the Committee meeting number one can be found on the DMHC's website as well as additional meeting materials affiliated with Committee meeting number one and two.

During committee meeting number one we heard from our quality and health equity subject matter experts on California and national trends, from each of the consumer representatives about the individuals and populations that they represent, and their thoughts on health equity and quality; and from the purchasers here in California, including the Department of Health Care Services, CalPERS and Covered California about their work and activities in this space as well.

A few of the comments and themes that we heard during the first meeting included discussion about data sources and validity, gender inclusivity,

including SOGI data, and alignment of measure sets.

With that, we have a very packed agenda today and so want to get going. I am going to now hand it over to Janel Myers, we are going to move to the next slide, who will take us through housekeeping. Janel.

MS. MYERS: Thanks, Sarah.

For Committee Members, please remember to unmute yourself when making a comment and mute yourself when not speaking.

For Committee Members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item. For those who wish to make a comment please remember to state your name and the organization you are representing.

For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. To raise your hand click on the icon labeled Participants on the bottom of your screen then click the button labeled Raise Hand. Once you have asked your question or provided a comment please click Lower Hand. All questions and comments will be taken in order of raised hands.

As a reminder, the Health Equity and Quality Committee is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene act can sometimes feel inefficient and frustrating, but it is essential to preserving the public's right to governmental transparency and

accountability.

Among other things, the Bagley-Keene Act requires the committee meetings to be open to the public. As such, it is important that Committee members refrain from emailing, texting or otherwise communicating with each other off the record during Committee meetings because such communications would not be open to the public and that would violate the Act.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Committee members emailed, texted or spoke with each other outside of a public Health Equity and Quality meeting about the matters within the Committee's purview. Such communications would be impermissible even if done at the same time. For example, number one emails number two, who emails number three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Committee members outside the confines of a public Committee meeting.

And as a friendly reminder, due to the Bagley-Keene Open Meeting Act, the Committee members should also avoid using the Zoom chat.

MS. BROOKS: Great, thank you, Janel.

All right. So as Janel mentioned, this meeting is subject to Bagley-Keene requirements and so as such we will take comments from the public throughout the meeting after each individual agenda item and just noting that we will want to make sure that we hear from everyone during those time slots and we look forward to your comments.

So I will walk through the agenda briefly today. We will start with opening remarks as we are right now, or we did. We will move into DMHC

remarks. We have a presentation by the data quality experts looking at current and future initiatives. We will have discussion around guiding principles for measure selection and focus areas and so that will include a presentation but also some significant discussion by the Committee itself as we move forward and consider what should be included as recommendations to the DMHC. If we have enough time today we are going to get to number 5, which is a preliminary discussion on measures; so that will be time permitting. And then we will close out with public comment and closing remarks. All right, next slide, please.

At this time I am going to do a quick roll call of DMHC representatives and Committee members just to see who is here today so we will walk through these slides. Mary Watanabe?

MS. WATANABE: I am here, good morning.

MS. BROOKS: Nathan Nau?

MR. NAU: Good morning, Sarah, I am here.

MS. BROOKS: Chris Jaeger?

DMHC CHIEF MEDICAL OFFICER JAEGER: Good morning.

MS. BROOKS: Anna Wright?

DMHC EQUITY OFFICER WRIGHT: I am here, thank you.

MS. BROOKS: Good morning. Sara Durston?

MS. DURSTON: Good morning.

MS. BROOKS: All right, next slide. Anna Lee Amarnath?

MEMBER AMARNATH: Good morning.

MS. BROOKS: Bill Barcellona?

MEMBER BARCELLONA: Present.

MS. BROOKS: Dannie Ceseña?

MEMBER CESEÑA: Present.

MS. BROOKS: Alex Chen?

MEMBER CHEN: Here.

MS. BROOKS: Cheryl Damberg?

MEMBER DAMBERG: Present.

MS. BROOKS: Diana Douglas?

MEMBER DOUGLAS: Here.

MS. BROOKS: Lishaun Francis?

MEMBER FRANCIS: Here.

MS. BROOKS: All right, next slide, please. Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Here.

MS. BROOKS: Edward Juhn?

MEMBER JUHN: Here.

MS. BROOKS: Jeffrey Reynoso?

MEMBER REYNOSO: here.

MS. BROOKS: Rick Riggs?

MEMBER RIGGS: Present.

MS. BROOKS: Bihu Sandhir?

MEMBER SANDHIR: Yes, good morning.

MS. BROOKS: Kiran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: Present.

MS. BROOKS: Great. Next slide. Rhonda Smith?

(No audible response.)

MS. BROOKS: All right. Kristine Toppe?

MEMBER TOPPE: Present.

MS. BROOKS: Doreena Wong?

MEMBER WONG: Good morning, present.

MS. BROOKS: Silvia Yee?

MEMBER YEE: Good morning, this is Silvia.

MS. BROOKS: Good morning. All right, Palav Babaria?

MEMBER BABARIA: Present.

MS. BROOKS: Alice Chen?

MEMBER CHEN: Present. Good morning.

MS. BROOKS: Good morning. Stesha Hodges?

MEMBER HODGES: Here. Good morning.

MS. BROOKS: Julia Logan?

(No audible response.)

MS. BROOKS: Robyn Strong?

MEMBER STRONG: Here.

MS. BROOKS: Next slide. And just quickly, this is a list of the Sellers Dorsey team that is supporting this project. We won't go through announcements, just for your reference, though. All right, next slide. All right.

So, we will now take questions and comments from Committee members. So as we mentioned, after each agenda item we will take public comment -- comment from the Committee members and from the public. As a reminder, please remember to state your name and affiliation for transcription purposes. And just checking to see if, Shaini, do we have any raised hands from Committee members?

MS. RODRIGO: Not at this time.

MS. BROOKS: Okay. So we will now take questions and

comments from non-Committee members. Same things apply in terms of stating your name and affiliation for transcription purposes. And just noting that as we go through with public comment we will limit to two minutes just to make sure that everyone has the ability to voice their opinion today and looking forward to hearing all the great comments. Shaini, do we have any raised hands from non-Committee members?

MS. RODRIGO: There are no raised hands from the public at this time.

MS. BROOKS: All right. So I am going to now turn it over to Nathan Nau to provide DMHC remarks.

MR. NAU: Thank you, Sarah. Good morning, everybody. Thank you for attending our second committee meeting. The Department thought the first meeting was extremely enlightening and informative and we think that should continue today with our baseline conversations and even beginning to talk about the measures if we have time. We will continue to listen and follow the workgroup very closely and we look forward to the final recommendations that will be coming later this year in September. Next slide please.

During our first meeting we had a few questions on what are DMHC's next steps and role in this matter and so we wanted to provide some brief thoughts and timeline on what that would entail. Next slide, please.

So our mission statement: DMHC is here to protect consumers' health care rights and ensure a stable health care delivery system. Next slide, please. Thank you.

So as I mentioned, the next immediate step after this Committee is finished is we would receive final recommendations by September 30th.

And beginning in measurement year 2023, which is next year, the measures and benchmarks that DMHC select will take effect. Our administrative authority also begins in measurement year 2023.

For calendar year 2024 the health plans would be required to report data for the results of measurement year 2023.

And in 2025 the DMHC will produce its first annual report, which will be published on our website. Next slide, please.

In measurement your 2025 the DMHC enforcement authority begins and this will allow us to address performance deficiencies for the benchmarks that we identify.

And in terms of measurement sunset, this would happen no sooner than five years. And if the DMHC decides to make any adjustments and measures we will have to reconvene the Committee and run that information through the Committee for feedback.

In terms of our enforcement approach for measurement years -- sorry -- for years '23 and '24 the DMHC may assess administrative penalties for violations relating to health plan data collection, reporting and corrective action implementation or monitoring requirements.

Measurement year '25 and beyond the DMHC may begin assessing administrative penalties for failure to meet health equity and quality benchmarks.

And then it is anticipated that the measures and benchmarks will be codified in regulation beginning in 2026.

So Sarah, I will send it back to you and team to see if there's any questions or comments.

MS. BROOKS: Thanks, Nathan. So we will start off by taking comments from Committee members. As a reminder to state your name and affiliation. I see a hand raised already. Shaini, if you don't mind I am going to go ahead and call on Rick Riggs.

MEMBER RIGGS: Hi, good morning, Rick Riggs from Cedar-Sinai. The question that I had was regarding the timeline as of September of '22 and then a measurement year beginning in 2023. For data pieces around understanding how to pull that data would seemingly take some infrastructure to be able to do that, especially if the fields or decision pieces are not there within the environment already. That would take quite a feat to have that up and running by January.

And then the reports you are going to collect. The other question I have is you are going to collect the 2023 data and then it is -- but it is not actually going to be published until 2025. So we actually might not know how to respond to that as an industry with that maybe partial year the first year and then not being published until 2025. So I just had some reflections around the timeline.

And then with enforcement beginning in 2025 and the publication coming out in 2025, how to close maybe that gap with regard to organizational expectations.

MR. NAU: Thank you, Rick. And correct me if I am wrong but it sounded like you are making more statements and I wouldn't disagree with any of the points that you brought up. As a matter of process, just to give a little bit more of information, the DMHC will be tracking what is discussed in the Committee and we intend to release an All-Plan Letter that outlines our measures and our benchmarks prior to 2023. And so we will be working on the

framework of the All-Plan Letter and we can be placeholders for what the Committee will be recommending so we can quickly get that out. But that still wouldn't address some of the data components and other issues in terms of closing gaps that you are mentioning so that is going to be something that we are going to need to hear from the Committee on and what the recommendations are and how to move forward. But the data points that you are mentioning are of particular interest to the Department and to have discussions on.

MS. BROOKS: Thank you. It looked like Bill had his hand up next.

MEMBER BARCELLONA: thanks, Sarah. Hey, good morning, Nathan. I just needed a quick clarification from you. Did you say that the measures would have to remain in place for five years and the only way they could be changed is if you reconvene the Committee?

MR. NAU: That's correct.

MEMBER BARCELLONA: Okay, here is a statement. That's a very rigid process. I mean, what we have learned from the IHA process, for example, over the last 15 years is some measures don't work and so you have to revisit them continuously to see what works and what doesn't and then modify as you go along. So I think that's a, that's a -- is that something that you are bound by statute to follow?

MR. NAU: We can follow-up but I believe so.

MEMBER BARCELLONA: Okay, thank you.

MS. WATANABE: If I can just jump in here really quickly. I will say, you know, I think we mentioned at the last meeting, again, this is Mary Watanabe for anybody that can't see me. This is really why we wanted to focus

on existing measures, particularly measures that have been and tested and we have good data around them. I will also just reiterate that in order for us to take enforcement we need to be able to have these measures codified in regulation as well. So there are some just -- some legal constraints around us having to do this.

We also in terms of having the measures in place for a period of time, really want to allow time to gather data, see if certain interventions or improvements will work, and so there's really, we want to be careful that we don't constantly make changes and so there's not the opportunity to really focus on making improvements and doing the things that we know will be needed to move the needle. So again, just a reminder about how we had really envisioned this being about 10 to 12 core measures that are already currently collected where we have good data on kind of what, what things look like across the industry, but adding this component of a health equity benchmark. So hopefully that context is a little bit helpful.

MS. BROOKS: Thank you, Mary and Nathan. All right. I think, Bihu, you had -- or Kiran, you had your hand up but it looks like you took it down; is that right? All right, Bihu.

MEMBER SANDHIR: Hi, I am Bihu Sandhir from AltaMed and I just wanted to -- it is more a statement, I think. Just echoing what Rick said that I think I have the same concerns. I think, you know, it's -- I think, Mary, you just helped by clarifying that it is measures that I think we are already familiar with, which would be, which I think took some of that concern away, because I do feel like it takes time to actually. We are looking at, well, setting targets but also the infrastructure, I think is a big concern; is how do we actually collect the data?

And then again, how do you make it actionable and act on it? So the timelines, I think we need to keep that in consideration as we move forward or at least pick measures that we really can, can actually, you know, work with, so that we meet these timelines. So I think it's either way. That was just a statement I wanted to make.

MR. NAU: Thank you.

MS. BROOKS: Thank you. All right, Kristine.

MEMBER TOPPE: Yes, thank you. I just wanted to make two comments related to what was sent around in the materials and the comments here with respect to the timeline for benchmarks and then also the inclusion of the measures specifically in regulation. The one point to follow up on would be whether or not it is the measure and then the specifics of what goes into that measure, because those things can be evolved over time as measures maybe, you know, need to have codes adjusted or what have you. So I am coming with that very specific kind of technical aspect in mind. So that's just one thing to consider as you are, as you are kind of working through what would actually be codified.

And then the second part is related to kind of the timeline for benchmarks. And so we -- and my colleague will be speaking to the work we are doing on this shortly. But the benchmarks we hope to have available would be around the same timeline. But if they are not available, for whatever reasons, those may be, we might, we would want, I think, to propose some flexibility around the state using, you know, benchmarks that are state versus national and so forth. So those are just some considerations to factor in as you are kind of building out those, those expectations. Thank you.

MR. NAU: Thanks. Sarah, I had one quick comment and kind of piggy-backing off of Mary's comments earlier as a matter of perspective. So I came to the DMHC from a health care purchaser so there was contracts in place. So think about it where, you know, whatever part of the delivery system, you work in, provider to plan, plan to delivery system. DMHC doesn't have contracts. And so one thing I have learned is our contract is really the law and so that's why the measures would eventually have to be codified. So hopefully that adds a little bit of perspective.

MS. BROOKS: Thanks, Nathan.

All right, I see Edward has his hand up.

MEMBER JUHN: Thanks so much, Ed Juhn from Inland Empire Health Plan. This is a comment as well as a question blended into one. Regarding the timelines, is there an opportunity for some of the data elements that are ultimately selected that might be in existence and codified already to kind of look at existing file fields that exist today? For example, at the state level with A34 (phonetic) files, to see if there's ways that we can improve on those pieces first, in parallel, as the organizations are building the infrastructure to have the capabilities to capture the 8 to 10 measures that are ultimately selected? Would there be an opportunity for looking at data elements that exist today and how we can optimize those pieces in parallel during measurement year 2023?

MR. NAU: Yes, I would think so. We want to report out all the measures, you know, any way we can and what makes sense and so I think anything that is currently available is something that we are going to want to talk about, especially if it is currently available.

MS. BROOKS: Thank you, Ed. All right, any -- Doreena. Doreena, you are on mute.

MEMBER WONG: Sorry. Yes, Doreena Wong with ARI. I was wondering in terms of the timeline, and I apologize but I cannot remember how long this Committee is going to be in existence and be able to respond to, to that timeline. I believe that the Committee was going to, I know, at least be around until the report is issued. But given this timeline and I was wondering if we would have an opportunity to be able to provide feedback around, you know, after September?

MR. NAU: Yes, so the -- currently the Committee would run through September, which is when the final recommendations are due. We are also required to reconvene and if we want to make any adjustments, but we are always looking to collaborate; and so getting additional feedback and having more conversations down the road is something that we would be open to.

MS. BROOKS: All right. So I think it looks like no more hands at this time from the Committee members. Shaini, do we have any hands from the public raised?

MS. RODRIGO: There are no raised hands at this time.

MS. BROOKS: All right. So we will move on to the next slide then. All right.

So we are really lucky today to have with us three of the leading experts in the field with respect to data quality and health equity. We will be hearing from IHA, NCQA and RAND. They will be providing us with an overview of the work that they have done to date thus far in those areas, health equity and quality. Just a friendly reminder to the panelists in terms of using acronyms and

other kinds of technical lingo. Just to, you know, keep it on a lower level for people like me that need that assistance.

I am going to now turn it over to Kristine. And I will just ask Kristine and Anna Lee and Cheryl, as you do, as you do your presentation please do a brief introduction of yourself and who you are and where you are from. So thanks so much and, Kristine, I will turn it over to you.

MEMBER TOPPE: Great, thanks, Sarah. We appreciate the opportunity to orient both the Committee and those listening to who NCQA is. I am joined today also by my colleague, Rachel Harrington, who is a subject matter expert and one of our researchers leading our health equity measurement work. I am going to provide an orientation for you on what NCQA is and what accreditation is and then she is going to talk really at a deeper dive on the, on the measurement, on the health equity measurement piece.

I am the Assistant Vice President for State Affairs at NCQA. I have been with NCQA for 24 years, focused on our work in public policy and then leading our state strategy since 2010. I am a resident and native of California so heavily invested in all things that we are doing here today and the outcome of this great work. So if we can go to the next slide. Am I, am I, okay. Next. Okay, and you can go to the next one. Great, okay.

So for those who may not be familiar with NCQA, we are a private, independent nonprofit health care quality oversight organization founded in 1990. We believe people need help to know where to find good care so we evaluate the quality of organizations such as health plans, health systems, providers, provider organizations and community based organizations. Our evaluations have broadened from health, from health care to include coordination and

delivery of long-term services and supports, and how organizations are working to address equity. We create standards, measure performance and highlight organizations that do well, and we do this with the aim of driving improvement, saving lives and keeping people healthy. So the next slide.

So we were asked to provide kind of a level set on what's happening in California with respect to NCQA. And I would say that NCQA has had a long history of support from, from healthcare organizations in commercial, in the commercial market, Medicaid market or Medi-Cal marketplace and in Medicare. But now we are at a unique place and so what I am going to share with you is just kind of a summary of the ways in which the various state stakeholders are using the accreditation.

So as you may know, the Department of Managed Health Care included -- is now implementing, if you will, a requirement that commercial health plans through AB 133 seek NCQA health plan accreditation. In addition as part of AB 133 we are here today to explore health equity measurement. And so NCQA has a vested interest in that lane as well because that is a critical part of how we are looking to expand how we evaluate organizations. That health plan accreditation requirement goes into effect January 2026.

And on the next slide you can see the other, the other critical state stakeholders, we have DHCS and its requirement that went into effect with its recent contracts, or RFP, that the health plans both be NCQA health plan accredited as well as seek the health equity accreditation, again in alignment with January 2026 requirements.

Covered California with the 2022 contracts named NCQA as the sole accreditor, they are the first in the country to do so. QHPs are required to

be accredited and Covered California is the first to name NCQA as the, as the sole choice. They also are requiring the health equity accreditation of QHPs.

And then CalPERS has had a long standing contract requirement for health plan accreditation and I believe is exploring how the health equity accreditation may be an opportunity for them to kind of reinforce that same set of expectations for the members that they are serving.

So this gives you a sense of the kind of impact that the state is trying to have in terms of aligning quality, aligning on equity, and really focusing plans on a kind of a single set of goals and coordinated set of goals so that they can be focused in the communities they serve and the members that they are supporting. Okay, next slide.

So I was asked to give kind of a level set on what accreditation is and so I wanted to give you a flavor for that so we are focusing on kind of the four things that I think are most relevant here.

Health plan accreditation is, is really the kind of comprehensive program that NCQA has to evaluate plans on, on kind of six core areas of function. And so it is really a kind of a comprehensive framework of standards that gets at -- I will go into kind of the details of what the standards area are in a moment but it is essentially our way of looking at a plan across the board and evaluating them on the structures and processes they need to have in place in six core areas, as well as evaluating them annually on clinical performance through HEDIS and patient experience through CAHPS. So that's kind of, that's the expectation that the, that the state agencies have for the plans that are serving their members, to get the health plan accreditation.

HEDIS is the clinical, you know, set of measures that many states

on the Medicaid side as well as commercial side, Medicare requires, QHPs are required to report this clinical set of measures that are, that we develop and publish annually and that we publish national benchmarks on. So it has become a very trusted source at the state and federal level for evaluating clinical, clinical performance. And then the CAHPS data that goes along with that when you are accredited with NCQA is the kind of complement to that to assess how, you know, is the experience of the patient supporting the, the needs of the member? If we can go to the next slide. Thank you. Okay.

So health equity accreditation is relevant here because it reinforces the measurement piece that we are going to be talking about more today. So it really, the health equity accreditation is the next generation of NCQA's multicultural healthcare distinction. It builds on that program, which was founded really in cultural competence and assessing the kind of class, the cultural and linguistic-appropriate services needs of members.

But it, but it is expanded and enhanced because now it includes organizational readiness, which means that the organization is really doing that internal look at DEI, the diversity, equity and inclusion. Does the organization kind of look like the members that they are serving? Are they doing the things that, that will generate equity within the organization so that they can actually do that work for the members that they are serving? It also includes requirements around data system capabilities and gender identity and sexual orientation data collection, as well as mandatory reporting of stratified HEDIS measures, which you will hear about more about today.

The last bucket is forthcoming, it is not yet published, and it is called HEA+ or Health Equity Accreditation Plus. And it is designed to build on

the health equity accreditation and focus the role of the organization in the context of the larger community in which it operates. So these standards are intended to be a framework for collecting and analyzing data, to understand the social risks of the community that the plan is serving or the organization is serving, and the individual needs of the population.

And then establishing community and cross-sector partnerships to address the individual's social needs and collaborate to mitigate broader upstream social risks. And it recognizes that it is not looking to disrupt current community organization initiatives, it really emphasizes the need for collaboration and understanding what resources are currently available. So very, very much has been informed by what is happening in California with CalAIM and the Medicaid contracts, with what Covered California is doing, and with other states across the country who have this focus. And that new set of standards, that additional set of standards is forthcoming. We are looking at a May time frame with surveys to begin in July.

And then the last part of my section is really to give you an overview of the specific health -- again, going to the kind of core program that all of the health plans in California will need to be accredited for.

Health plan accreditation is looking at quality management, population health management, network management, utilization management, credentialing and re-credentialing, member rights and responsibilities, and member connections. So that very comprehensive view of, you know, what a plan needs to have in place in order to kind of deliver the right care at the right time in the, in the way that best meets the needs of the member.

We look at -- so from a process standpoint, we look at policies and

procedures, documented processes and evidence of implementation to validate that plans are meeting the standards. And the outcome of that evaluation is an accreditation status, which is posted on our report card, so publicly available, and updated monthly to refresh those accreditation statuses and include any applicable and NCQA corrective actions that may have, that may be underway if the organization has had issues, you know, during the survey process or in between survey processes, that can happen as well. So we really work to be very transparent and make sure that the public and our state partners know what is going on with the plans that we accredit. So I think the important piece to that, you know, as I mentioned before, is that in California, you know, the state public purchasers and regulators have chosen to harness that uniform evaluation of plan quality, which, you know, we believe will provide the alignment needed for health plans to focus on key quality priorities for the, for the populations that they serve.

And then the last little, the last piece of this, excuse me, is really just to describe to you what the survey process can entail. And so there's really three options.

For plans that have never been accredited before or need to have accreditation as part of kind of the beginning of a contract period, that that's been the case in some parts of the country, we have an interim option and it is really almost like a readiness review. Do you have all of those systems and processes in place in order to serve members? It is not intended to be a one, you know, one look and then, you know, come back over a long period of time. We come back 18 months later and then review them against not only their structures and processes but the implementation of those through the evidence

that they have done the work that they, that they had said that they were going to do and that their systems were built to support.

And so then once plans are, have gone through that, if they choose to do that, they go through the first survey. The first survey is a full, a full-blown comprehensive survey of all of the things that I have mentioned, including the evidence piece, and it requires the submission of the HEDIS and the CAHPS data.

And then the renewal is just that ongoing process.

And the -- once a plan is fully accredited they are reviewed on a three year period.

And so that is really kind of an orientation to the core NCQA accreditation program and then the complementary health equity focused areas.

So with that, I am going to hand it over to my colleague Rachel Harrington who is going to do a deep dive for you on the health equity focus pieces of our work that are really the subject, the core subject of this group's considerations. Rachel.

MS. HARRINGTON: Great. Thanks so much, Kristine; and thanks, everybody, for letting us speak with you today and to share in this discussion. As Kristine said, I am Rachel Harrington. I am a research scientist in NCQA's performance measurement group and I am going to try and connect the dots between some of our work on the standard side, which Kristine described, and also our work on the measurement side, and how we are bringing forward our equity strategy. Next slide please.

All of our work comes back to the concept of the idea that quality care is and must be equitable care, and that you can't have quality without

equity. And because of that we really see the importance of building equity into all of our programs, our accountability standards, our measures, our research and so on. Next slide.

NCQA has active projects in a number of areas, bringing together, like I just said, standards, measures and research to achieve the goal of integrated equity across our work. I am going to walk through a couple of them here and discuss how they relate to each other.

The Health Equity Accreditation Plus Kristine just described is a standard that supports plan and community partnerships and action on unmet social needs. This work is supported by the California Endowment.

On the red we have our Equity in HEDIS work. This I am going to go into more detail in a couple of slides, but it is really focused on both increasing transparency and disparities as well as changing how we think about equitable, inclusive measures. Next.

Next we have our work funded by the California Health Care Foundation to create a health equity accountability framework for measurement. The focus of this work is specifically on the Medicaid managed care in this case, but we are designing it in a way that we hope is extensible to other use cases as well. This framework is slated for release this summer and we are excited to try and bring together all of these different concepts of equity and measurement into hopefully a useful tool in decision-making in this space.

Finally, we have work supported by the Commonwealth Fund to develop recommendations for policy makers and health care entities on how to improve the quality and collection of race and ethnicity data. There has been a lot of progress in this area over the last year or two but we know there are still

questions here and hope to support organizations as they are, you know, working to really build this portfolio of data that we need to take action.

So I hope you can see through some of these different efforts the different ways that we are thinking about equity in terms of data, research and accountability.

Next slide.

So this slide can be a little bit much at first glance but I will walk through it. It is charting our standards and HEDIS measurement work together on the same timeline so you can see sort of how they link up and how different initiatives are releasing in comparison to each other. The blue on the top is our standards work and the red on the bottom is our measures work.

Kristine already discussed, we had a long-standing program called the Multicultural Healthcare Distinction that has recently evolved into our Health Equity Accreditation; keeping that focus on race, ethnicity and language but also integrating additional requirements. This was released this past fall.

Then we are in the process of developing our Health Equity Accreditation Plus that focuses deeply on the social needs and social determinants that is releasing - I apologize for the typo in this slide - in, it says March, it should be May of 2022. So that is sort of the journey that we have been on with our standards.

Simultaneously we have been moving our measurement work forward. So along the same path, we started with the stratification of a select set of HEDIS measures by race and ethnicity, published for the first time for HEDIS measurement year 2022; and we will be expanding that stratification to additional measures each year for at least the next couple of years and honestly, probably

quite beyond that. There is only just so much space on the slide.

The earliest this data will be publicly reported, so available in terms of public benchmarks and in public data assets, would be in 2024 covering the HEDIS measurement year 2023 period. And that is because, as we do with any major change like this, we hold the first year of data to do a first year analysis to review things like reliability, validity of a plan's ability to report and really make sure that the data that we would share with the public is really reflecting a interpretable and useful set of, set of information. So 2024 would be the first year that some of that data would be, would be available.

In addition to the stratifications, each measurement year we are also targeting additional equity elements, starting with our social needs measure and then also working on topics around sexual orientation and gender identity. Next slide.

And actually, if you could click twice, please, there is some animation here that I just want to go through. One more time, please. Perfect. Thank you so much.

So I spoke a little bit about our health equity accreditation, the new base program, and Kristine described the standards here. But what I want to highlight are how some of these elements link directly into the measurement strategy that we are working on, specifically the requirements for collection of race, ethnicity, language, and SOGI data. These standards go into sort of minimum expectations around the data needed to have equity focused population health management, but also measurement and transparency.

And then in the last element at the bottom, there is required reporting of quality measures stratified by race and ethnicity, ensuring that we

have transparency into the performance and that organizations have a way of standard, having a sort of standard way of evaluating their outcomes and performance. So we really do see standards and measures as being sort of intrinsically linked here, making sure the structural elements are in place to support the measurement, transparency and accountability. Next.

All right. So I am going to shift focus now to get more into the detail in our measurement work. I have mentioned some of these topics like the race and ethnicity stratification already. But here you can see some of the different directions by which we are approaching equity right now. And this certainly isn't the end-all and be-all, there are other topics we are considering as well such as social isolation and language.

But I wanted to sort of share these here, the race and ethnicity stratification. We have a socioeconomic stratification for a set of our measures although this is available for the Medicare product line only. Our work on a social needs screening and referral measure and our work on gender affirming measurement. What I would like to highlight, really the take-away from this slide is that stratification, which is the transparency into differences between groups, is critical and necessary, but we don't believe sufficient for equitable measurement.

We also believe we need to think about what new measure concepts are needed to address the upstream needs and unmet needs that we know are so critical into determining health outcomes, and which health plans are increasingly investing in addressing. But we also think, and gender affirming measurement is a good example of this, that we need to rethink how our measures are speaking to populations. That we are taking inclusive measurement approaches so that the right people are getting the right care

without, for example, conflating biology and identity. Next slide.

So when we introduced our race and ethnicity stratification I mentioned we started off with a subset of measures; there were five of them for measurement year 2022. And our -- we sort of intentionally decided to start small and start focused to let stakeholders build the processes and data needed to successfully report on these measures. So I just wanted to briefly show what those five measures were. You will see the first three here: colorectal cancer screening, controlling high blood pressure and hemoglobin A1c control for patients with diabetes.

And then on the next slide we have our second set, the prenatal and postpartum care and child and adolescent well care visits.

All of these measures bridge different product lines and populations, including the commercial product line, which we believe really can't be left out of the equity discussion. And you also see different domains of quality, access, utilization, prevention and screening, really showing that equity cuts across all of these elements of our sort of quality measurement ecosystem. Next.

So here we have our selection criteria for how we went about choosing measures to add the stratification. I am showing the criteria for measurement year 2023, but it is functionally the same for those first five that I just showed. And we frame our criteria in terms of exclusion and prioritization criteria. We excluded from consideration, at least in this first set and first couple of years, those measures which have risk adjustment; measures which were in first year status, which would mean brand new, new to the scene, still untested, still getting their legs under them; those measures slated for retirement. This

was a sort of burden consideration. We didn't want to stratify something that was going to be replaced in the near future. And then we excluded measures where we knew there were considerations around small denominators. We sort of looked at the distribution of denominator size across the 90-plus measures in HEDIS and really tried to say, you know, if they have got, if they are in the smaller end of that distribution, if we know plans struggle to report even without stratification, then you know, we are not going to put the stratification in place here at this time.

On the flip side in terms of prioritization, we prioritized measures that had high priority for disparities. Now, what does that mean? It is a mixture of two things. One is sort of clinical public health epidemiologic evidence. Is there a well-documented disparity? Is there a sort of pressing public health need in a particular area? And then we also looked at policy priority, what were states, federal programs, private programs focusing on in terms of taking action?

We also wanted to make sure the measures we selected represented, I say multiple product lines, but I think the way to translate that for this case would be multiple populations, we didn't want to over-focus on any particular one group.

And then finally, and this might seem a little bit strange, but I would like to point out our prioritization of digital measures. These are measures that have digital logic and are calculated off of clinical data sources directly. And we see the move to digital measures as being critical for equity measurement because it gets us away from the need for manual samples, which present a problem for stratification sample size and instead takes us back to looking at the full population eligible for a measure denominator. Next slide.

So we are in the process of finalizing our measure list for stratification in measurement year 2023. I can't share what those measures are today but we did put 14 measures out for public comment and you can see some of the clinical and topic areas listed here. I can say that we received a really strong signal that we need to add measures around behavioral health and substance use disorder so it would not be surprising if you see some of those measures included in our set for the next measurement year. Next.

Shifting now to our new measure for social need screening and intervention. You can see the description on the screen but to sort of boil down all of that text, this measure has two types of rates: The percent of the eligible population who was screened and the percent of those who screen positive, who receive an intervention within 30 days. Now there is more detail in all of that than I can reasonably get into in today's discussion, but a few things that I will highlight. This is a digital measure. It is designed to be calculated directly off of clinical data sources, building on data standards developed by the Gravity Project via Health Level 7 and others.

It focuses for now on food, housing, and transportation because that is where the data standards have matured. That is where we have the structure fields that we can use for purposes of measurement but it certainly may expand to other domains like interpersonal violence or economic instability in the future. And then the measure does support multiple screening tools, prepare, accountable health communities, vital signs and others, recognizing that there are different tools in use in the field that might be suited for different populations. Next.

The screening measure is specified for all product lines, there is no

restriction on age. You can see the proposed exclusions and age stratifications on this slide. We realize that for age in particular more granular stratifications may be important for understanding the dynamics and quality improvement. But the fact that we left it to these three is really based on sort of the balance of sample size considerations needed for accountability and reporting for making valid comparisons between groups. And then next slide.

So just to wrap up with some of the lessons learned that we have had from, from these efforts. I won't read all of this. I welcome the participants to skim it and I am certainly happy to answer questions on any of the details.

What I will highlight is that throughout our work a few things keep popping up. First, the ability of data standards to support this type of measurement. There has been an incredible evolution in the data environment over the last year or so that really is giving us the ability to expand how we think about measurement.

But there are areas that are still in flux. The standards around gender identity and sexual orientation are a good example of that, with there being still some differences in different parts of the data ecosystem.

We are continuously working through questions around data privacy, interoperability and data sharing, with a question that commonly comes up being, where is the source of truth? Where is the single source of some of this data that we should lean into? And sort of understanding where we can collect once and reuse things like race and ethnicity potentially, versus things that we need to collect more often, like social needs, that we know can change over time.

There is a common theme around building trust with members by

clearly sharing why this data is being collected, how it will be used and how it won't be used. And the necessity of planning community partnerships as well as appropriate resourcing to be able to support these partnerships.

Finally, I will end on, you know, I have been talking a lot of this in terms of different efforts, race and ethnicity, gender affirming measurement, socioeconomic status, social needs. We treat them as different categories for now because that is sort of how we are grappling with them. But I think we all have to acknowledge that these things intersect with each other, they don't exist in isolation, and we need to do more work to understand and acknowledge that in terms of how we hold ourselves accountable in this space.

So with that I will wrap up and turn it over to the next presenter.

MS. BROOKS: Thank you, Kristine and Rachel, that was, that was wonderful.

We are going to now hear from Anna Lee Amarnath.

MEMBER AMARNATH: Good morning, everyone. I am Anna Lee Amarnath and I am the General Manager for Integrated Healthcare Association's Align Measure Perform Program. So in my background, I am a family physician and prior to working with Integrated Health Care Association I did have the opportunity to work for several years with one of our state departments, the Department of Health Care Services. So all of that goes into play to say I am very interested in the work that we are doing in California on equality and equity and I am really excited to get to continue that work with Integrated Health Care Association now. Why don't we go to the next slide.

So who is the Integrated Healthcare Association? We are a nonprofit business league; we are funded by the healthcare industry. And since

1994 we have collaborated with our cross-industry board of directors really in the pursuit of a healthcare system that works for all. We have a number of programs that are part of our organization. I am going to talk a lot about our Align Measure Perform Program but there are other aspects of our program, Atlas, our Encounter Data Governing work, our work with HCAI on the all-payer claims database, as well as the work we are doing on Symphony, which is a provider directory. Let's go to the next slide and talk a little bit more about IHA.

One of the things that we try to do is bring the health care community together to overcome barriers to providing high value care. Our goals are to find alignment around shared goals and use data and insights to help everyone improve. But it can be hard to improve what you can't measure, that is why we are all here. And measuring performance isn't easy. There are different measure sets, different methodologies that can provide different results even for the same populations, and limitations to the data that can give a real incomplete picture of how performance is happening. That is where our Line Measure Perform Program comes in. Go to the next slide.

So this is a statewide voluntary program for plans and providers that measures everyone by the same standards to create clear, reliable results and performance benchmarks. We utilize an aligned set of measures that tracks quality, resource use and cost of care; and we utilize a committee structure filled with subject matter experts across industry that ensures our measures are selected that have high impact on outcomes. Let's go to the next slide.

A couple of things that might make us a little bit different than some of the presenters we heard at the last committee meeting: We serve as a neutral, impartial, kind of third party. We are not a state regulator, this is a

voluntary measurement program. We have implemented a number of processes to ensure the quality and validity of the data that we are collecting, the calculations that are being generated, and the results that are being released. And we also host a neutral questions and appeals process that has been seen to be very valuable to both our plans and provider organizations because this allows them to better understand what their data shows and potentially correct their data if errors in submissions are found, which really can help improve the process of data collection and reporting. Another great asset of our program is that we do provide performance results not only at the health plan level but also at the provider organization level as well. Go to the next slide.

So in our Align Measure Perform Program, currently we have 12.1 million lives. That includes 10 million commercial lives, 1.8 Medicare Advantage lives, and a little over 300,000 Medi-Cal managed care lives. I would just note, that is a relatively low amount of Medi-Cal managed care participation in our program and we fully recognize that greater participation would allow for better comparisons kind of across lines of business and that is one of the areas that we are hoping for growth in our program as we go forward.

We also have Atlas, which is a publicly available set of information that covers 16 million lives in California. That is 90% of California's fully-insured commercial population and 70% of California's Medicare Advantage population. So what is Atlas? Just really quickly because I am not going to focus too much on it today. I just wanted you to know it is publicly available. It is California regional care, cost and quality Atlas. It compares quality and cost using two dozen standardized measures and views that information by geography and product lines, so you can really do a lot of comparisons as you are looking at

quality and cost across the state. Let's go to the next slide.

So how does our program work? It is about having a common measure set, sort of what we are talking about in this committee as well, and how we can set benchmarking that helps focus on quality improvement and how we can use resources more efficiently.

We also provide our participants with a voluntary health plan incentive design where health plans could elect to use that to reward high performing providers.

And our results are publicly reported through the Office of the Patient Advocate as well as public recognition awards that we provide to really reward the highest performing provider organizations as well as those that demonstrate the greatest improvement year over year.

Now, one part of our Align Measure Perform Program that I want to talk a little bit more about is the Advancing Primary Care Initiative. IHA and the California Quality Collaborative and the Pacific Business Group on Health have facilitated a stakeholder process to come to a common agreement around a designed set of measures meant to advance primary care.

What does it mean to advance primary care? It is around ensuring high quality, lower cost primary care that keeps patients really at the center of every interaction. It is about having a high standard of attributes that are either in place or need to be developed. It is really a fundamental principle. It is really about making sure this definition is around the patient and how patients experience care.

What you see here is just some broad categories or domains of measures. These are a subset of our Align Measure Perform Program

measures that are part of the Advancing Primary Care measure set. They fall in the areas of clinical quality, patient experience, resource use and cost. The measures within these buckets were discussed through that stakeholder process and approved through our and our partners' committee and governance structures. It is meant to be a small focus set of measures that demonstrates advancement in primary care that is in place, and clinical measures that are outcomes or clearly linked to outcomes. It is meant to be measures that can be impacted by primary care.

We are also about to be engaging in a pilot of this Advancing Primary Care Measure Set with some of our partners who are on the call today, Covered California, CalPERS, also the city and county of San Francisco, and also eBay, which I find very interesting. One of the intents of this pilot is to make sure we are doing alignment that also allows for aggregations, because aggregation is necessary to ensure the reliability of measurement at the provider level. And that allows us to do aggregation across payers, both plans and IPAs, to really reflect how physicians are practicing. Go to the next slide.

So within IHA one of the things we are doing, in addition to working on how we can improve quality of care across the industry, is really talking about what can we do and how can we support the industry when we are thinking about equity? And how can we think about disparities with the data that we have or that we could have?

One of the efforts IHA has undertaken is to really look at the data we currently collect and see what is available to us and how could we improve that data? And like everyone has discussed either on this call already or our previous calls, we recognize there is an inconsistent capture and a lack of

standardization of the data, which does make this difficult at times to match the data that we have to some of the claims and encounter data that is available. But we need to think about how we can develop a consensus on how to use that data to improve health equity.

When we dig into the data that we have from our participating plans and provider organizations we do collect data on race and ethnicity and we see that about 42% of the members that are represented in our data do you have a populated race indicator in that data set. Only 6% have a populated ethnicity indicator. There is also a Hispanic or non-Hispanic indicator which is populated about 7% of the time. That does not sound like high numbers when I say that to you and I want to again reflect on the fact that this is data that is being collected voluntarily and one of the important initiatives that may come out of the work that we are doing here is as we begin to see more and more plans and providers beginning to collect and report this data we will be able to use this data in new and better ways. Let's go to the next slide.

So when it comes to thinking about how to improve or better collect race and ethnicity data we are looking at not only what can be collected directly, and, for example, was collected and reported to us through our program. There is also opportunities to think about indirect estimation and how can those be used either in connection to allow for better analysis and reporting, perhaps to better inform policy-making at the state. Next slide, please.

I just want to briefly mention one initiative that IHA partnered with RAND and our data vendor Onpoint on, which was to look at RAND's imputation methodology, a way of indirectly estimating based on surname and address someone's race and ethnicity; it produces a set of probabilities that a person

belongs to one of these sets of race and ethnic groups. And we took this methodology, and RAND is speaking next so I don't want to say too much about this, this is our partnership with them and our data vendor, but we utilized this methodology and tried to do a test to see if this was applicable to the data that we had and how could we use this? Again, recognizing that the data that we collect within our program is not as complete as we would like when it comes to race and ethnicity. Next slide, please.

So using this as a proof of concept we were able to show that we were able to impute race/ethnicity with about a 92 to 97% accuracy level for the groups that are part of this methodology. Again, it was a proof of concept, but we haven't yet validated this against self-reported race and ethnicity data in our claims data and that might be a potential next step that we want to consider if we were to start to think about the value of imputation methodologies if direct collection is not currently available.

That is not to say that that is necessarily going to be a better choice. Direct collection is generally, I think, pretty well accepted to be the best way to collect this information. But we may be in a situation where some plans and provider organizations are further along and is there any value to consider imputation as a mechanism to get additional information to inform policy making and other decision making that has to happen? So an idea to consider as we move forward. Next slide, please.

So within IHA what we are trying to do is establish through our committee structure recommendations on what our role can be to support the industry in improving health disparities. Whether that be focusing on how can we improve the data, how can we use that data both within our programs or outside

of our existing programs, as well as how we can support state and policy and regulators in decision-making that has to happen.

Part of that is participating in groups such as this; we are also working at a national level as well. IHA has been a part of the Core Quality Measure Collaborative for Measure Model Alignment; it is a workgroup discussing promising practices and barriers to measure alignment that we will be developing a guide that will soon be available. And we are also participating in the Core Quality Measures Collaborative Health Equity Work Group, a multi-stakeholder group trying to develop a report summarizing equity-related measures and disparity-sensitive measures that are currently in core sets that may be considered or that may be considered for future inclusion. And how we can address challenges and implementation and adoption of equity-related measures for quality reporting and payment purposes.

So we are really looking forward to the work of this Committee so that we can consider thinking about how we want to align kind of across the state; but also what this means at a national level as well so that we can all focus on improving quality and equity instead of focusing on different disparate measure sets where we are instead focusing on methodologies and different ways to collect the data. Instead, what we really hope to see as an outcome of this is better alignment so that we are working together in the same way towards those same improvements.

So I will close there. Thank you so much. I will turn it over to Cheryl Damberg, our next speaker, from RAND.

MEMBER DAMBERG: Thanks, Anna Lee. Can folks hear me?

MEMBER AMARNATH: Yes.

MEMBER DAMBERG: Okay, great. So I am a Senior Researcher at the RAND Corporation; a background in health economics, health policy and health services research. For those of you not familiar with the RAND Corporation, we are a nonpartisan, nonprofit, research organization that focuses on conducting research, applied policy research, to help inform decision-making amongst decision-makers, both in the private sector as well as in the public sector. And my background in particular, I think many of you know me, at least those of you who work in California, as I have been involved in a lot of the quality measurement activity here in the state, but also nationally. And my particular area of emphasis has really been around development of performance measures, the use of those performance measures in a variety of applications, whether it is for transparency-type applications, public report cards, consumer choice, as well as in the context of value-based payment programs.

And Rachel had mentioned, you know, in the context of work that NCQA is doing and its approach that, you know, the area to try to address the issue of equity and closing the gaps that we see, the disparities gaps, it is really a multi-pronged approach or effort. And I wholeheartedly agree with that comment and I think that performance measurement and the use of measures is only one of many approaches that have to be applied to address the problems that we see in the data. So I just want to use that as a framing for what I am going to describe for you next if we go to the next slide.

So this, the four points that I will speak to today are captured in an article that I wrote last year with a colleague of mine at RAND, Marc Elliott, who is a senior statistician and has done a lot of work around health equity and disparities. And these are four areas where performance measurement can be

modified to try to help address disparities in healthcare and I am going to talk through each of these in the following slide, slides that I present today.

So if we start with the first area in terms of measuring performance accurately, the goal there is to try to reduce provider incentives to avoid taking care of disadvantaged patient populations. And the issue here is that in many performance measurement programs the providers who disproportionately care for disadvantaged patients tend to perform worse on these quality measures and some of that is a function of being under-resourced to begin with. And if, you know, the stakes are high in these value-based payment programs, providers may look to be more selective in terms of who they choose to care for or enroll in their health plans. So we need to be mindful in the construction of all of these performance-based accountability and value-based payment programs that we don't create incentives for providers and plans to do things that lead to unintended consequences.

So let's go to the next slide and I will talk about one of the strategies to try to mitigate against that particular risk. So a key component of performance measures is the validity of the measure. When there is bias in measurement the measure is not valid; and I will give you kind of the quintessential example from many years ago. Some of you may recall that Medicare decided it was going to produce mortality rates for all the hospitals in the country. This was when they were known as HCFA. And they decided to do so without risk adjusting for differences in the patient mix in terms of their clinical severity. And this generated a lot of backlash. And the importance of adjusting for the clinical risk factors that patients present with at the hospital is that those patients are at different risks of dying and so that is essentially outside the

control of the provider. What is inside the control of the provider is the quality of care that they deliver when presented with different patients.

So similarly, in the context of disparities, what we have observed when we have looked at data, so if you think about disparities, there are two components to disparities. There is what I call the between-provider or between-plan disparity and the within. And the within disparity is measuring the extent to which there is systematic difference across all plans or all providers in terms of differences in the quality of care delivered, which suggests that there may be things that are outside the control of the provider that required different means to address than quality measurement itself. So our approach has been to decompose the disparity into the between versus the within and to examine that and to look to see where the within-plan disparities exist and to adjust for that within provider disparity. So if you go to the next slide.

So one can either do what I would call direct adjustment for various social risk factors in the context of statistical models, progression models, or as in the case of the Medicare program, because they are not the measure steward they are using existing measures and they have created what I call a back-end adjustment that mirrors direct risk adjustment. And what this is doing is it is adjusting for these within provider or within plan differences in, say, the Medicare Star Ratings Program, but still preserving the between-plan quality of care differences. And what case-mix adjustment is doing is it is producing the scores that plans or providers would receive if they all served the same patients; so it levels the playing field in terms of making comparisons. Let's go on to the next slide.

So another approach to addressing disparities and improving equity

is to make disparities visible. And Rachel and team discussed what NCQA is doing on this front. CMS is also actively involved in this space in terms of producing stratified performance scores for health plans, Medicare Advantage plans, in the United States.

And in this example, if you were to go to the Office of Minority Health website you would see stratified reporting of two types of performance measures, both clinical and patient experience, of care measures.

And they have stratified them by race/ethnicity and by gender for these Medicare Advantage plans.

And how Medicare is approaching this - so Rachel mentioned a number of times issues related to small samples - is they are pooling data over two years to generate accurate or reliable estimates of performance by these subgroups to be able to differentiate performance at the subgroup level across these plans.

And they require a minimum of 100 cases per subgroup so that would be for Black patients, Hispanic patients and so on. And they also enforce a minimum reliability standard of .6 to report results.

And reliability refers to, in its most simple form, are you picking up true signal versus noise in the estimates? So when you get small numbers to work with you tend to have a lot of noise, random variation in the estimates. And so you improve reliability by either having more denominator in a given year; or another way to do this is by pooling information over multiple years to, again, enhance the denominator to get a reliable estimate. And I liken sort of the reliability measure to, for any of you who are baseball fans, if you think about the number of times a batter comes to bat and what their batting average is. So

would you say their batting average is 30% if you only observe them 3 times versus 300 times? And, you know, they could hit home runs on those first three and then not again for a very long time. So what you need to see is repeated observations to get sort of a good read on the signal of performance, whether it is at the plan level or the provider level. Let's go on to the next slide.

So the third piece that I am going to talk about, and this is really new territory, that is, I would say, in the process of development, which is developing measures of health equity. And I am going to give you two examples.

This first is really a proof of concept, the HESS score, and this was work that was done for the Office of Minority Health.

The idea around this measure was to characterize the quality of care delivered to Medicare patients with social risk factors and to create a summary index or measure of health equity. And the way this works is it is combining data across multiple measures, both HEDIS clinical quality measures as well as the CAHPS patient experience measures. And it is including multiple social risk factors in the construction of this index. And in this case the proof of concept was modeled with two types of variables: One, the dual eligibility for Medicare and Medicaid, and LIS stands for Low-Income-Subsidy that beneficiaries receive if they are in Part D prescription drug plans if they are low income, and then race/ethnicity. And let's go to the next slide.

So I am going to describe for you in very high-level terms how this measure is constructed and then I will show you a visual, again, to give you a conceptual idea of how people are approaching construction of equity measures.

So similar to the stratified reporting that I mentioned to you moments ago, this measure includes a cross-sectional score based on the two

most-recent years of data, again, to try to provide more stable estimates of performance to improve the reliability or the accuracy of those estimates.

So there is this cross-sectional score but there is also an improvement score. So the cross-sectional score measures a point in time and the improvement score is looking to see how plans or providers are improving over time. So it is including a comparison of the two most recent years to the prior two years. And the objective here is to try to encourage plans or providers to narrow the within-plan differences in performance. So whether that is differences in colorectal cancer screening rates for Black patients versus white patients and so on.

And that the improving quality for those with social risk factors is compared to national benchmarks.

So if we move to the next slide, this is a conceptual diagram of how this measure is constructed. And I would call out that there is a published paper in the *Journal of General Internal Medicine*, the first author is Denis Agniel, and it was published in 2019, that describes this test of this measure of feasibility testing. And what you see on this figure, so let is start at the top part of the figure, so we are looking at race/ethnicity as the first social risk factor. And as I mentioned, there are two components. So first we look at the improvement for a given plan. So closing the gap, you know, between different race/ ethnicity groups within the plan compared to improvement nationally and that gets melded into the improvement score. And then there is the cross-sectional score component and those two pieces get blended together for the race/ethnicity score.

And similarly, this is done for the second risk factor which gets at

the social risk around low-income status. And again there is the within-plan improvement in terms of trying to look at closing the gap for duals and non-duals compared to the benchmark, and then there is the cross-sectional score, and those two are, again, blended for the dual eligibility/low-income status portion of the score.

And then finally you get to the overall index which combines for the different social risk factors you are looking at. So this feasibility test tested for these two different types of social risk factors but this model is very flexible and could consider any type of social risk factors that were important to whoever is constructing the measure. So let's move on to the next slide.

So I am going to describe for you an approach to another type of health equity measure, referred to as the Health Equity Index and this is being currently proposed by CMS in its 2023 Advance Notice.

And what this measure does is it summarizes the Medicare Advantage plan performance among those with social risk factors across multiple measures similar to the HESS and it summarizes it into a single score. And Medicare is proposing to initially include as the two social risk factors the person's disability status, and their income status as measured by either being dually eligible for Medicare and Medicaid or receipt of a low-income subsidy.

And what this does, so it is looking at the distribution of the plan's performance on each measure for each social risk factor. So if you think about this, so you would have colorectal cancer screening for duals and you would say, if you performed in the top third of the distribution of performance for duals for colorectal cancer screening you would receive one point, if you were in the middle third of that distribution you would receive zero points for that measure,

and if you were in the bottom third you would receive minus one point. And you would do this for each of the measure/social risk factor combinations. So let's go to the next slide.

And then given the context here, which is the Medicare Star Ratings Program, they assign different measures different weights. So to get to the index they are constructing the measure as a weighted sum of the points across all these different measure/social risk factor combinations to generate the weighted sum of the number of eligible measures.

And so CMS refers to these Medicare Advantage plans as contracts. So the contract performance on the index would vary from minus-one to positive-one, showing that performance was in the top third for each of the included measures.

And if we go to the next page I am just giving you some insights as to what CMS is proposing. They currently have a reward factor that they are looking to replace with this new Health Equity Index. Again, with an eye toward trying to incentivize improvement in the quality of care delivered for those populations where performance is lagging.

And one of the things to also note is that as you think about constructing these types of measures we have talked about small numbers problems and how to potentially mitigate those issues in terms of pooling data over more time periods or potentially ramping up data collection. So if you think about current NCQA HEDIS measures that draw a sample of somewhere around 400 cases per plan, one approach is to start stratifying the data collection such that you collect more information per population subgroup of interest.

CMS is kind of thinking about this in the context of using the health

equity index by imposing a threshold of saying that there would need to be some minimum percentage of enrollees in the plan with those social risk factors to be eligible for this particular reward factor. And the reward factor gets added at the back end to the construction of the Star Ratings, so it would effectively give plans that perform well in terms of caring for patients with social risk factors a bump up in their Star Ratings measure. So let's now go to the next slide.

So I realize that this is not specifically the focus of this committee but I wanted to also note that we have been doing some thinking and work around the structure of value-based payment programs and thinking about other means for addressing disparities. And I think we collectively know that there are structural issues that contribute to the problems of disparities and we see payment inequities across different providers in the system, particularly providers who disproportionately care for Medicaid patients but who also may serve Medicare and commercial patients.

And so if you think about the resources that any given provider is able to amass based on the mix of patients it sees, those providers who disproportionately see patients with some of the social risk factors tend to have a poor payer mix, if you will. And so they have fewer resources to invest in quality improvement to try to close these gaps and do the type of outreach to patients to get them in for care and to potentially offer additional flexibilities for patients to receive care, improving access.

So if you think about sort of the base that they are working from as kind of fewer dollars and then you layer on top of it a value-based incentive program that potentially pulls resources further away from them by virtue of them performing more poorly and thus not being eligible for incentive dollars, we feel

like there is a way to try to mitigate those negative effects within these incentive programs while still encouraging high performance.

So we modeled, and we have done this in a number of cases, where we start with -- so we are now at kind of the back end of the program where a payment allocation is being made. And what we do is we group the different providers based on a set of characteristics, whether it is patient characteristics such as differences in the income levels of the patients they see, or provider characteristics such as, let's say, the percent of Medicaid patients they see. And what we are doing is we are grouping the providers say into four categories based on these characteristics. So at one end you would have providers who say have a high proportion of Medicaid patients or a high proportion of patients with low-income and at the other end you would have groups that see more affluent patients and have a better payer mix.

And as we look at the value-based payment incentive we would hold the mean payout constant across subgroups. So if the mean payout is let's say $2 per member per month on average, we would hold that constant in each of these groupings of providers. And then we would distribute the dollars within those subgroups of providers based on differential quality performance within. So that is the place where you are retaining the incentive for doing better means higher rewards. So if we go to the next slide.

MS. BROOKS: And Cheryl, just jumping in, we just have a couple of minutes left. I know you are getting close, I just wanted to mention it to you.

MEMBER DAMBERG: Yes. Yes, sorry. So we found that this approach nearly doubled payments to providers that care for disadvantaged patients and it reduced the payment differentials across providers according to

the patient's income, race/ethnicity and region.

So that is all I had to describe for you today and will be happy to take questions when we get to that place.

MS. BROOKS: Perfect. Thank you so much, Cheryl. We will move to the next, one more slide, please. All right. So thanks to all of our presenters today, that was excellent. So much information and I know lots of probably thinking going on, thoughts going on right now. We will start with an opportunity for questions, comments from the Committee. Are there any raised hands right now? I see Alice.

MEMBER CHEN: Thanks, Sarah, can you hear me?

MS. BROOKS: I can.

MEMBER CHEN: Great. First, just wanted to thank all of the presenters. Those were phenomenal presentations, really rich and I think really useful information. I did just want to reach out to my NCQA colleagues. Really nice - and I actually have questions for each one of them but probably don't want to clog up this forum, per se, for some methodologic issues, I will reach out but for - nice to see the folks from NCQA.

I just did want to share, one, appreciation for starting to lean into social needs screening, I think that is a really important area. Our team did put in a formal comment letter but unfortunately I missed a piece of it so I just wanted to share it here, particularly since I think people on this call would have similar thoughts. As you know, we have been leaning, we have been working very hard to align across the three Ms, you know, Medicaid, Medicare, Marketplace. And so I would really encourage NCQA to look towards the CMS MUC list because as you probably know, a measure just went through, it does

differ in some substantive ways. I frankly don't really care that you have three measures instead of five because I am all about parsimony, as you know.

However, I do think that the way it is constructed around a percentage screened and then percentage positive would be really important, because I think we are skipping a step to go from percentage screened all the way to people who received an intervention. And I will say that there is a lot of concern, as I talk to people about it, about the loose definition of intervention. So I just wanted to not get into too much detail but, one, just say this is an important area for all of us, particularly given CalAIM, to start looking into. But I really fear that we may -- or what I want to do is prevent kind of proliferation of different flavors and see if we can align with what is already happening at CMS. And I think NCQA is an important partner given everything that you showed about all of us and pointing our health plans to NCQA for accreditation in furthering that alignment. Thanks.

MEMBER BARCELLONA: Alice, what was the name of that list again?

MEMBER CHEN: It was the Measures Under Consideration but it did actually get approved by NQF and CMS is now deciding which programs -- gotten approved for both the hospital quality program and the MIPS program.

MEMBER BARCELLONA: Thanks.

MS. BROOKS: Thanks, Alice.

All right, Rick.

MEMBER TOPPE: Sarah, did you want --

MS. BROOKS: Yes?

MEMBER TOPPE: I'm sorry. Did you want Rachel to respond? I

think she might have a comment on that.

MS. BROOKS: Yes, that would be great. I apologize.

MEMBER TOPPE: Thank you.

MS. BROOKS: Thanks, Kristine.

MS. HARRINGTON: No problem; and I will keep it brief because I know there is a lot of discussion. Alice, thanks so much for sharing that comment and for providing the comments during the public comment period. So much comments. Just as a note on alignment. We are definitely aware of the measures on the Measures Under Consideration list. There are a couple of key ways that they, they differ and we have been in conversations with CMS and other stakeholders around, you know, alignment now versus alignment in the future and why we took some of the decisions that we did.

I will say one of the things that we struggled with is the way that those measures are set up as two separate indicators. If you have the pot percent positive without knowing the percentage screened, and I think this is a general consideration that that is worth discussing amongst the group. If you, if you pull those two things apart and don't look at them in tandem you run the risk of a little bit of a cherry-picking situation happening where you could choose to screen a certain population that you know might have a higher or a lower positivity rate. And if those measures were proposed to be interpreted as lower is better. So if your lower positivity is better you can see how you kind of get into an interesting tension in terms of who you screen and who you are targeting for.

But all that said, I think just to echo, we completely agree on the alignment front and we are hoping to move in that direction.

MS. BROOKS: Thanks, Rachel. Any other responses from the

panelists? My apologies.

All right. Rick.

MEMBER RIGGS: Yes, thank you to all the presenters for the great, overwhelming sort of, information actually, that was presented, it is a lot to digest.

One of the things that I would like to just come in on is the self-reported versus attributed pieces around all of the SOGI and, you know, race and ethnicity pieces. I think we have seen some sensitivity data coming out that, that the ability to self-attribute is actually, you know, the most accurate. And then if we are, obviously, we are taking information and stratifying it based on our attribution I think that we may have gaps there that obviously could lead to unintended consequences.

And then the other piece that I would just like to comment on was around the sort of ability to have these new types of measures, or new types of screening tools like the Health Equity Summary Score really sort of adopted and how that might, how we might encourage that as we look towards standards. And I know that is what this group is about but I just point out that we have talked about a lot of different new ways of looking at this and models today in the data that has been presented and understanding that this would represent a lot of integration, again, for folks that are doing this work to respond to all the different sectors.

MS. BROOKS: All right, thanks, Rick.

Dannie.

MEMBER CESEÑA: Thank you for the presenters. I had a question and I apologize if this was answered in the presentation and maybe I

didn't hear it correctly. But with many low SES patients, when they visit a provider for their care with many complaints about their health or symptoms that they are experiencing, they are dismissed due to their lack of education, gender identity, and many times even due to high weight gain. So a lot of times, you know, cancer or other diagnoses such as endometriosis is caught in the later stages because they have been dismissed, or the patients will not return to the provider because they did not feel heard and will provider hop trying to find someone that will actually listen to their concerns. So how would these measures not only acknowledge and identify these situations, but identify a solution?

MS. BROOKS: If any of the panelists want to take a stab at responding to Dannie initially with respect to the work that you are doing.

MEMBER DAMBERG: Dannie, that is an interesting set of comments that you have raised. I think I need to give it a little more thought, you know, because historically measurement has required that a patient be with a provider for some duration to kind of hold that provider accountable. And so I guess the question is, are they -- so if we are thinking about risk-bearing organizations in the state of California, are they hopping between different plans or are they just hopping around between providers within the plan? But again, I think one would need some additional data, you know, particularly around things like gender identity, to be able to analyze and understand what is going on in that space. And I think just kind of writ large, you know, this is sort of the challenge we collectively face about how much information we have to really kind of understand the issues, to then figure out how to address it.

MS. BROOKS: Thank you, Cheryl.

MEMBER AMARNATH: One thing I just wanted to add to what Cheryl was saying, and I think this is, Dannie, to your point. This is one of the benefits of having data available that is really across providers, across payers across lines of business. I recognize that what we are discussing here around setting measures and the accountability that DMHC will have authority over for certain health plans does lead to exactly what Cheryl was talking about, there are certain people who may drop out of that accountability if they aren't with a health plan for a certain amount of time.

But the benefits of having data available that kind of crosses lines of business and providers over time, what that really helps allows you to do is potentially segment by populations that are churning between payers or providers. It is a real opportunity that I think on our Committee as well we have our Office of -- HCAI, I'm sorry, I got your acronym wrong, HCAI, as we are really thinking about what the future might look like in California with the all-payer claims database and/or the potential future Office of Affordability. So I think there is really a lot of opportunities to think about how we can look at that population. And I am not sure if DMHC's regulatory authority would necessarily capture that but there is definitely a lot happening that I think will be really interesting to see what we can do with that information.

MEMBER DAMBERG: Yes, and I just want to emphasize what Anna Lee just said of the all-payer claims database. Because the goal there would be to be able to track individuals over time and really understand their care trajectories and look at differences. So I do think that we are going to be in a stronger place in a few years to be able to really get a better understanding of this space.

MS. BROOKS: Thanks, Cheryl.

So we are going to move on. Just a friendly reminder to everyone to state their name and affiliation just so that everyone knows who is speaking. And then also just remember to not use the Chat, guys, just because for Bagley-Keene purposes.

All right, so Jeff, it looks like you are up next.

MEMBER REYNOSO: Thanks, Sarah. Jeff with the Latino Coalition for a Healthy California. Thank you all for the presenters.

A recommendation for next time, if there is an opportunity. There was so much content. For those of us that don't live in the healthcare quality world day in and day out it would be helpful to have a pause after each presenter to ask questions and maybe we limit the amount of commissioners/committee members that ask questions.

You know, I think from our perspective, really commend NCQA for their work on the Health Equity Plus measurement. I think it gets to this concept of health equity that addresses the need for partnering outside of the health care sector and thinking about health plans as similar to what has been done with hospital community benefits and the work of hospitals as anchor institutions in supporting local community-based organizations that address the broad upstream factors that impact health equity. So I really commend you on that and would love for this Committee to explore that further.

I guess two questions. It might be for the NCQA folks and maybe I missed it, but at what point does a measure become a standard and what does that process look like? And for the work of the Committee and our task at hand here, some of the, some of the measures are indexes and, you know, they are a

little bit more robust. So wanting to learn more in terms of the work that we do here. Are we able to select from an index measure that, you know, kind of captures a more robust picture of what it is that we are trying to ultimately measure for, for the population to advance health equity?

MEMBER TOPPE: I am going to ask my colleague Rachel to step in, she can provide the most comprehensive answer to that.

MS. HARRINGTON: Well, I will try and take the first piece. I think the latter question around the indices and sort of how we navigate the individual parts versus the whole is a larger discussion that I think others might have, have some thoughts on.

Regarding the standards becoming a measure or standards versus measures. I think it is worth thinking of them as two separate things. The standards go beyond your typical quality metrics, they have structural requirements, sort of frameworks for how to act or behave or interface or handle things. Measures can be a part of that. They can be part of the accountability, they can be part of the quality improvement efforts, but they are slightly different things in terms of how they are, they are managed and handled.

That said, I think both of them in terms of how NCQA approaches this, from taking them from concept to production and sort of getting them out in the field is a sort of multi-stakeholder evaluation process. So we would typically do things like, you know, coming up with the concept, vetting the concept through stakeholder engagement. We have a number of standing panels at NCQA, but we also go out into the community and try and talk to organizations and individuals and partners who are working in a certain space. There is typically a pilot testing process for the measures that goes through a very

detailed, quantitative-type testing. The standards might be a mixture of sort of feasibility and quantitative and more qualitative work to understand where they are falling. And then, you know, sort of going back into the stakeholder engagement process to make sure we are going in the right direction.

From NCQA's perspective, all of our measures and standards do have to be sort of voted into public use through some of our governance committees, making sure that we are meeting the requirements we think we need to in terms of, you know, meeting the needs of the field, taking the right conceptual approach, taking the right methods approach to things.

So it is a very iterative process. I think some folks on this panel may have been part of that for some of our different work. But we really think that is critical to make sure we have something that is, that is appropriate and usable and making sure that it is well vetted. So I will stop there and I might turn the second question over to, to Cheryl or to other colleagues on the call.

MS. BROOKS: Any thoughts, Cheryl, or should we turn, check with others?

MEMBER DAMBERG: I think we probably should move on because I see a lot of hands.

MS. BROOKS: Yes, I was going to say --

DR. BASKIN: Sarah? Sarah? It's Andy.

MS. BROOKS: Yes, Andy.

DR. BASKIN: It's Andy. Just about the health indices. I mean, this is something that will be discussed at a later time. Actually, some of it actually today and in future meetings when we talk about health equity measures; and indices can be a topic of discussion and actually should be a topic of discussion.

So I would ask that we kind of postpone that until we, until we get to that part of the process, either this meeting or the next meeting.

MS. BROOKS: All right, that sounds good, thanks, Andy. All right. So as Cheryl mentioned there are lots of hands up, which is great, because that means there is lots of interest and we had a really good panel. Definitely heard you, Jeff, in terms of thinking about how we approach presentations and questions so thanks for that comment there. I don't think we are going to get through everyone's comments. What we are going to do is come back later if we have time and if not, we will make sure to get the questions and share both the questions and the responses with both the Committee and with the public as well. So I think we have time for one more question in this space and I do apologize because there's lots of hands up. Silvia actually had her hand up next and so I am going to go with her and then I have got a list written down of everybody else that had their hand up.

MEMBER YEE: Thank you, Sarah, the weight of this is upon my shoulders. One is a comment and question and then I do have a second question that is more specific.

So the first one, I was noticing in many of the NCQA slides some statements that I totally agree with. That you can't improve what you can't measure. And that stratification and transparency into disparities is necessary for advancing standards but not, it is not sufficient in itself. And I noted that NCQA prioritized groups, populations with studies that have established they are subject to disparities.

And I just have to call out here again that the general lack of demographic information about disability status means that there is a really

tough circle to break into here. That if you are not recognized in the first place, and in many, many health contexts it is not, disability is not recognized as a, as something to collect for demographic purposes and therefore, for stratification. It is really hard to get those studies, it is really hard to establish the disparities, and that it just continues in a cycle that is extremely hard to break into. If there are ideas on the panel on how, on how to break that cycle I would very much appreciate that.

I do also want to note that very recently in the last couple of weeks, the interoperability standards workgroup at ONC has included three disability elements, recommended that they be passed on, and I think that is a great first step, I hope that is part of breaking the cycle.

And then the second question was thinking about RAND's Bayesian Improved Surname Geocoding looking at surnames and I was curious about how that worked with regard to individuals with mixed race. And I am thinking of that specifically because, you know, the improvement I think was 92 to 97%. And for me I was thinking about, well, perhaps mixed race individuals could fall exactly into the percentage, admittedly small, that is consistently missed.

It reminds me of how several years ago NCQA I think was going to retire a measure of getting weight, getting weight from patients. Because almost everyone gets their weight. They are weighed when they go to see the doctor, consistently. But that doesn't happen with people who use wheelchairs or people who can't get on a scale. So you have -- it is very successful for most people and it doesn't work for a small percentage of people. But because you are not necessarily measuring the people that are missed they fall into a gap and

I think I have seen studies that people of, people with mixed race, mixed racial identity, have high disparate mental health, disabilities and stress factors. So I just wanted to raise these two things because I am thinking of people who fall in gaps. Thank you very much.

MS. BROOKS: Thanks, Sylvia. I think we will open it up to the panelists for just kind of a couple of brief comments.

MEMBER AMARNATH: I'd love to respond. Sylvia, I just want to thank you for your comments. I agree, when I joined IHA and I was looking at the data we have available and what we collect as part of our programs, there are definitely some gaps that are instantly obvious for those of us who are part of this type of committee as well, not able to collect information on disability status or SOGI information as well. So these are areas where we really are looking to see how can we, what are we driving towards as a state and as an industry and how can we kind of support that ongoing and how can we incorporate those potential types of gathering of data into the information we collect? Are there standards that already exist or how can we help facilitate the development of those standards? So I just want to agree and reflect that I see what you see as well and the limitations in what we currently have and how we are often limited by the data that we currently collect.

With the imputation methodology I also just want to agree and reflect on some of the comments you made as well. There are definitely some limitations. And I know Cheryl might have some comments as well. I don't think it is intended to be a replacement for direct collection of more detailed information, it is generally utilized at a level that is sort of at a very high level, a very high aggregate level, it doesn't allow for some of the disaggregation of

certain subgroups that might be of interest and worth looking at. Because when you do aggregate at a high level sometimes performance can be masked, if you start to think about what does that mean at just an aggregated level as well as who is not captured in that as well, such as people who may not clearly fit into one category versus another.

I don't know if Cheryl has any additional comments but I just want to reflect and say I agree with many of your, of what you are saying and some of the challenges that we face as both what do we have that we can use now? What don't we have that we need to start to figure out how to get? So Cheryl, I don't know if you wanted to add because I know RAND, this is your area of expertise, I didn't want to speak for you.

MEMBER DAMBERG: No, you did a great job, thanks. So, I agree. I think that we, there are any number of places where we don't fully understand the characteristics of the people who we are trying to better understand what type of quality of care they are receiving, and if they are receiving worse care, how to address that. And as Anna Lee said, the imputation method that was applied is intended to aggregate that up to, say, a physician group level or a hospital level or a health system level or at the plan level and it is not necessarily intended to be used on a person-by-person basis.

There is work going on to try to address the issue of people who would select multiple racial categories to try to improve that imputation method but, you know, I think there is recognition that that is one of the areas where the methodology could be strengthened. But if you look at comparisons of the imputation to what people self-report, the concordance, the agreement is very high so I'll just leave it at that.

MEMBER TOPPE: If I could just close out for NCQA on this. I think there is, it is interesting because -- and we definitely appreciate Sylvia's comments, they are not new to us. We are really thinking about this in all contexts, both on the accreditation standard side how our standards are written to evaluate organizations that are serving people with disabilities. And interestingly on the, on the dual kind of multiple, multiple races, sorry, point, our existing race and ethnicity specification actually can allow for that if it is direct reported, so there is some, you know, some capability for that. But obviously if it is imputed you can't get to that so it is a little more challenging. But just want to close out with that support and appreciation and acknowledgement.

MS. BROOKS: Thanks, Kristine. I know, there was a question for HCAI so I just wanted to see if Robyn wanted to have any quick comments in response to that. If not, we can move to public comments, but just wanted to check in with you, Robyn.

MEMBER STRONG: Yes, thanks so much. So Robyn Strong with the Health Care Access and Information, the new name at HCAI. And it was actually directly related to that and completeness. We at HCAI through our existing data collection programs have done a lot of work in the area of completeness, particularly for race and ethnicity.

And so I want to just recognize what Anna Lee shared so frankly with us on the percentage of completeness and recognize that that is foundational to be able to do that kind of striation.

So I appreciate the comments that you made, Kristine, also about how you are dealing with multiple races, kind of the flip side of completeness, you know, extra-completeness being handled.

So just wanted to make sure that that is front of mind since that takes a lot of work to make sure that that data is valid and useful and to make sure that it is not just 41%. I think that was the percentage you quoted, Anna, who we know the race data has been reported for. And that, you know, underscoring that for the other areas that we might be looking at using striation. So that was just my comment and wondering how NCQA handled that, although I understand that we are limited for time now so thank you so much.

MS. BROOKS: Thanks, Robyn. Yes, I think we are going to have to move on, I do apologize, I am just looking at the time. Let me see real quick. So we have a list of everyone who had their hands up. We will circle back with you if we don't get to that at this meeting so apologize about that but appreciate everyone's engagement here.

Just asking Shaini real quick, do we have any comments from the public? Any hands raised?

MS. RODRIGO: No, there are no hands raised at this time.

MS. BROOKS: Okay, thanks, Shaini.

All right, so we are going to keep going then. We are going to start down our path now of discussing the Committee's recommendations and how we are going to come to -- how we will facilitate that process and discussion with respect to helping you all come forward with what those recommendations are.

So to begin we are going to discuss overall guiding principles for measure selection, so some examples of what those guiding principles might look like. Measures will apply to full-service and behavioral health plans regulated by the DMHC. They can be meaningfully used by all DMHC-regulated health plans. Measures will be measurably and meaningfully improve --

measures will measurably and meaningfully improve quality for Californians. Sorry, that was a tongue-tie. Measures will measurably and meaningfully reduce disparities. The measures will be balanced, impactful and make sense as a set. Alignment with purchasers is a consideration for this measure set. And that the Committee will establish or consider established measures. So these are some examples of guiding principles.

Following this, we will move into a discussion about measures, measure focus areas, specifically after we talk about the guiding principles. Andy Baskin and Ignatius Bau are going to take us through this part of the presentation today so I am going to turn it over to them and we will get into the slides and then open it up for some discussion. Thanks, Andy and Ignatius.

DR. BASKIN: Thank you, Sarah. It is Andy, can you hear me okay?

MS. BROOKS: I can.

DR. BASKIN: Okay, great. I couldn't help get excited about the last three presentations and the conversation there afterwards. Certainly it is obvious that there is a tremendous evolution going on, or rapid evolution in the last year or so and in the near future regarding health equity measures and the use of quality measures to measure disparities, but some over-arching newer health equity measurement so, you know, pretty exciting stuff.

However, we have some practical considerations facing us today. We have to select measures for our charge and we have some limitations in that some of these newer concepts are not well enough developed for the type of initiative that we have here.

So we have put together some guiding principles to help us in the

measure selection process and then, as Sarah mentioned, we will also try and bucket this work into smaller questions by dividing up the measures into some potential focus area categories so that we can address each category one at a time and make it easier to come to some decisions to develop these.

In getting these guiding principles we looked at the program, the task that was given us by DMHC and we looked at some of the measure selection principles that are used in some current programs, either in California or some national programs. You see a list here of a few of them.

You are obviously familiar with DHCS and they had developed some criteria for their Medi-Cal managed care set of measures.

We were aware of National Quality Forum, they also have a set of criteria for measures for their endorsement.

The Measure Application Partnership, which was convened by NQF, the National Quality Forum, but they recommend measures for use in public programs by CMS. Go to the next slide, please.

You have heard mention of the Core Quality Measures Collaborative by one of our presenters today, which is a -- it is actually convened by NQF but it is a group that was put together initially by CMS and AHIP, the health insurance plans, but also includes providers, patient advocacy organizations and others. They have a set of measure kind of principles in terms of selecting the measures for their purposes.

National Academy of Medicine.

Many state Medicaid programs also have a measure selection criteria for their core sets. I don't think there is another group on the next slide but I -- no, okay, so go back to the other slide. No, you can keep it, you can go

ahead, I'm sorry. That's fine.

So in doing so what we did was we kind of looked at all of those principles and we kind of combined them to what made sense based on what we are trying to accomplish here today and we put together this set of criteria on this page as well as the next page. I will present them to you, they are just sort of things you should be thinking about as we start to select individual measures.

It is pretty obvious here that if you are going to select a measure there should be an opportunity for improvement. So, you know, it doesn't make much sense to select a measure where, where performance is already high and therefore doesn't really have a lot to be gained. Part of the goal here, of course, is to improve care and so where there are some gaps in care and significant gains possible that would be helpful.

And as mentioned on one of our prior talks, it needs to be impactful. Either because the measure may affect a large population or have a large impact on a smaller portion of the population. But nevertheless, just a sense that improvement, that the opportunity for improvement is actually going to have a reasonable, measurable impact on the population that is being measured.

Feasibility has to do with some characteristics of the measures themselves in that if you can't actually perform the measurement because the data, you don't have access to the data or the data doesn't even exist, obviously doesn't make much sense.

We also want to pick measures where the burden of the data collection and reporting is not too high. And you will see that as we talk about measures that there are some measures that are already currently being

measured so the burden to measure additionally for this purpose is less so. But then if we use measures that are not currently being used we want to make sure that the resources necessary to collect and report are not so overwhelming to our providers or managed care organizations that it kind of makes it very difficult for everybody.

And while it is not necessary that every measure be stratified, we already heard from NCQA about the five measures that are being, already being reported, stratified racial and ethnic subgroups and some additional ones coming in the future. It is very possible that we may want to do that with a few or all of the measures that we select so we should at least consider whether stratification is potentially meaningful for some of the measures that we are selecting. The next one, please.

Usability. I put this very simply in that we want to, we want to select measures that have been in use, that have some proven, they have proven to be successfully implemented in that they can be measured, the measured results are reliable, they are meaningful, they are accepted and the data collection and the processes involved have, kind of the kinks have been worked out.

This is not a testing ground for measures. We have a timeline where these measures are going to be used for some accountability purposes, for some enforcement down the line. There is going to be some time necessary, as already mentioned earlier, for people to see the first year's results, react to the first year's results, and then at a later time several years down the road some enforcement is based on the results. So using this as a testing environment doesn't make much sense to accomplish that goal so we want to have measures that have been used somewhere, preferably in California but not necessarily, but

have some proven ability to be implemented.

There are measures that are more sensitive to disparities than others because we know from studies or published data that, that disparities exist today. And even if we are not necessarily measuring them through stratification today we know that those disparities exist and we know that by improving the measure as a whole we are likely improving the outcomes of those who are currently under-served or who are on the negative end of the disparities. So there is some consideration of disparity sensitive measures and I think later on Ignatius will help us understand, you know, how to identify a disparity sensitive measure.

And of course California has some priority areas that need to be focused on. Perhaps it is inherent in what I have said or what you understand our charge to be, but I should mention that it must be reasonable to hold the MCO who is being measured accountable. We certainly don't want to select a measure for which the MCOs have little ability to improve the measure results.

So I will give a simple example. You know, if we were to decide to say that gee, measuring the patient's financial health would be a measure that we thought was helpful because financial health may result in poorer health care and related things, would you really want to consider the MCO as accountable for that and some enforcement of improving the financial health? While certainly health care has effects on people's financial health it is not necessarily the major one for the bulk of the population and that accountability would be a little far-fetched, I think. So that is all I am saying that you want to be thinking in the back of your mind, is this a measure that you think is reasonable to hold an MCO accountable for, because at the end of the day that is what is going to happen.

I will stop there. What is the next one? Sarah, are we, are we going to take feedback along the way or wait until I go through all the slides?

MS. BROOKS: Let's go through the slides so people get a full understanding of all --

DR. BASKIN: Great.

MS. BROOKS: -- everything and then we will go into discussion.

DR. BASKIN: Great, then let's, then let's move on. Oh, I have additional ones. Oh, okay. I had forgotten about this slide. So, one of the things about the burden of reporting we talked about was that, you know, some measures are already being reported in some fashion or another, whether it be to NCQA or through Covered California, IHA, Medi-Cal, you know, these examples are here. While we are not restricting ourselves just to measures that are used by those particular organizations, but when possible, to align with those organizations and measures that they may be using or that some other organization for which reporting is occurring today, certainly would be helpful to reduce the burden on the MCOs and the providers who are going to have to collect this information.

If we were to decide to use a measure, let's say, on a particular topic, let's say something simple like diabetes care, it would be nice to look at the diabetes care measures used currently today by these organizations that MCOs are already reporting in California to see if one of those diabetes measures that is already being used would perhaps be the best one versus picking a diabetes measure that wasn't currently being used. In other words, is there enough value in doing that to make it worth not misaligning with these programs, so we would hope that would happen.

Harmonization simply means that, gee whiz, if we pick, you know, if there are different versions of measures, you know, what is the best version of the measure that we should be using. Unfortunately, those of us, and many on this call who are involved in quality measurement, know that versions have been tweaked or there's variations of the same measure which somebody might think is the same measure but in reality the details behind it are not the same. So we got to be careful about that but we will deal with that as we move through. Let's go to the next slide, please. Okay.

So we have a big task here. There are a lot of measures in the measures universe. I mean, if you just go to an NQF site and look at how many measures have been endorsed, which is one, one way to look at the totality of measures, there are many, many hundreds if not over 1,000 measures. And if you look at just all of the programs, I mean, if you look at -- so if you just do a survey out there of what measures could be considered it is certainly close to 1,000 programs. And of course, we are trying to get down to a set of 10 to 12 that make the most sense for this particular initiative for DMHC to make a determination on.

It obviously doesn't make any sense to just look, take 1,000 measures and put them on a list and say, let's talk about each one and see what the pros and cons are and kind of rate them in some way or another. So what we are proposing to do, of course, is to break this down into some buckets, to make the decisions to narrow it down so that we can make some more meaningful decisions and sort of take off the top those measures which are so, so unlikely to be of value and not spend as much time on them. So the next slide, please.

So in doing so one of the things we are going to propose is breaking down the decisions to focus areas and I will give you what those potential focus areas would be and looking for your feedback.

But what we would do is determine what areas to focus on. Now these are, you know, so not to, not to make everybody wonder what is he talking about. These are things like, you know, a chronic care measure versus a coordination of care measure and those types of focus areas.

We will present you a list of proposed focus areas. We will ask you to comment and identify if we are missing something. Understand that there are measures, of course, that can fit into more than one focus area because they are kind of broad-based titles. So that if it didn't, if a measure didn't seem to fit in one, a measure didn't seem to fit in one focus area very well could fit into another focus area. We are not trying to limit what we discuss, we are just trying to break the decision-making down into smaller pieces for practical purposes.

We would hope that the process will be once we have agreed on these focus measures that when we actually get into measure selection we will basically take a focus area, one at a time, we will look at the potential candidates of measures and we will start out by looking at some behind-the-scenes work looking at all of the measures out there in the measure universe and then narrowing it down to the top candidates based on some criteria that I will discuss to present to the Committee. And then we will talk about those measures and hope that we can select maybe 2 or 3 measures which would be the most likely measures for a final set in that particular focus area.

Now everyone here can do the math. If I have 10 focus areas and we are picking 2 to 3 that is going to be well over our 10 to 12. And the reason

for that is I am just trying to get us to narrow it down to the top 2 or 3. Not necessarily pick the measure, because I don't know whether we are going to have just one measure in a particular focus area, I don't know what this group is going to want to do.

There will be some focus areas which at the end of the day we may decide no measure makes the final cut of 10 to 12; or that we have 2 within one focus area and none within another focus area because it is, because those are the best measures for what we are going to do when we balance out the set. But by doing this by 2 to 3 candidates per focus area, I think we have 10 proposed focus areas. We will narrow this down to the, you know, the top 20, 25 measures and then we will spend, you know, probably, you know, a meeting saying, okay, what makes sense to have a balanced set of measures? How do we pick and choose amongst these top candidates? Which is a much easier discussion once we have gotten it down from 1,000 to 25, to pick those final 10 to 12 measures. And we will go to the next slide, please.

We understand there will be some recommendations or some requests for measures which may not be feasible today. One is because they haven't met our criteria in the sense that they are not usable, they haven't already been into a program, or it is a new concept measure. Unfortunately, some of the stuff that we have heard this morning about, you know, some of the health equity measures are fairly new, they are just being finalized or they are early in their adoption period and some of them just would not be mature enough for us to use in this situation. And that can be the case in any of our focus areas, as it turns out. But we will put them to the side, we will put them kind of in the parking lot, and they certainly can be included in our report and we can express

the desires of this Committee for where, what direction to go in the future as these things do become mature enough to be practical to put into a measure set.

As I stated, measures can overlap on multiple focus areas. We are not trying to exclude discussion of any particular measure. And in fact, if a measure is not in our narrowed down list each time we talk about a focus area we will invite the group to tell us if there is any particular measure or two or three that they would like us to have some more deeper discussion around to consider and that may be we have not narrowed it down appropriately. And that would be fine. We are not trying to exclude, we are just trying to make the decision-making more practical. The next slide, please. Okay.

So what are the focus areas we have come up with? Well, we did this similar to the measure selection criteria. We looked out there at just some of the naming conventions out there as a way to say, how do we bucket these measures? And we looked at these various sources, as you can see, it is pretty obvious who they are. There is --

CMS has some listed focus areas.

NCQA has their HEDIS Domains, they call them.

Agency for Healthcare Research and Quality, it is a governmental entity, AHRQ it is known as.

Some of the current programs in California also have some titles for different measures that fit into certain buckets.

There are many states that have some incentive programs that also have buckets.

And we just generally looked at the literature to see how these things are spoken about in, in some of the publications. The next slide, please.

Okay.

And we came up with this set. Now understand that even in this set of focus areas we came up with a name that was sometimes, there may have been three or four names for a focus area that were pretty much the same area. For instance, you know, in preventive care we saw things such as, you know, Preventive Care would be a name of it or Staying Healthy would be a name. In other areas they may have multiple names, you know, Chronic Disease, Chronic Conditions may have been called. And we came up with what we thought was the best name but we are not, once again, trying to restrict what you think is in the bucket, we are just trying to give it a name for conversation purposes so we can talk about it.

So I will give you kind of an example of each one so that you will get a feel for the intent here. So the first one, Health Equity. While we talked today we heard a couple of actual great examples like this. This new social needs screening measure that NCQA was talking about or some of these health equity index measures. So these are more broad-based measures that not particularly, not a particular acute care or disease process or a condition or what but more of a general measure as to how health equity is being addressed. Those would be the types of measures there.

Ignatius, you are out there somewhere. I don't know whether you wanted to talk just a little bit more at this moment about the kinds of things we would consider under that health equity bucket?

MR. BAU: No, Andy, go ahead and I will come back.

DR. BASKIN: Great, great. Let me see, I don't have -- I just want to see if I have them in the same order you have them here.

Access. So access could be things like how many patients got a preventive health visit in a given year or how many adolescents saw the doctor in a given year. It is just -- there are various measures of access like that, which is essentially, you know, kind of measuring whether access -- there's any barriers to access and people are actually utilizing their health care appropriately. So kind of a more general thing there.

Prevention. I think it is pretty obvious that a lot of prevention measures are screening-type measures so we are talking like breast cancer screening, colorectal cancer screening or cancer screenings in general would be probably the most common example of that type of measure.

Coordination of care could mean many things to many people. But medication reconciliation, so you get discharged from a hospital and they reconcile your medicines as an outpatient, is a coordination of care between the inpatient and outpatient. That would be a very common measure that is talked about in coordination of care. So those types of measures.

Mothers and children, I think it is pretty obvious there we could have some measures specifically around maternity care would be a very common measure there. Childhood care could be immunizations or child well visits. And of course there is non-maternity care, which can be included for women's health as well.

As you can see, there may be some overlap. Obviously, breast cancer screening is most commonly considered a women's health measure but it is more a preventive category, I think, is where the discussion would be, as opposed to -- because it is a, it is specifically a screening measure. So, you know, once again, some of these things can fit into more than one category.

Chronic condition. So we are talking about measures of controlling high blood pressure, controlling diabetes, hypercholesterolemia measures, there is a whole host of them, but that is the type of thing that we are thinking about there.

Behavioral health. Follow-up after a mental health hospitalization or this could be something related to care of depression. There are some measures out there that are commonly used.

Substance abuse, similarly would be some measures like follow-up after, after hospitalization for a substance use disorder treatment. Or initiation or engagement of treatment for those identified with alcohol or other drug use would be samples of measures like that.

Population health measures could be measures like tobacco use screening or even weight screening or screening and cessation activities. Those might be considered population health measures.

Specialty measures can be a mix of things but just as an example something like, like there are some measures of the HIV viral load, which is a very specific measure but it is, it is -- I wouldn't call that the same as our chronic conditions, even though HIV could be a chronic condition, but it is a very focused measure on a particular situation and there are measures like that to consider. Something else may be dental or oral health type measures would be what we would consider in a specialty realm.

Utilization measures would be measures such as, you know, use of emergency rooms or use of urgent care centers, or -- well, one could -- well, I will leave it at that. But there are a lot of measures that just measure how often things occur and whether those are rising or not rising in certain kinds of

utilization of certain types of care.

And patient experience is essentially -- the one that is most mentioned there is the CAHPS survey, you have heard that mentioned today. We didn't say what CAHPS stands for, that acronym, but it is Consumer Assessment of Healthcare Providers and Services. But it is, it is a survey. There's many versions of a CAHPS survey depending on how it is used but it asks a lot of questions about patients' experience with their health plan, with their providers, with their care in general. And there are certainly other experience of care tools out there that could be considered.

So those are the categories that we came up with. We think pretty much most measures would fall into one of these ten categories, or we would hope they do. And I guess at this point, I don't think there is another slide, I think it is time for me to kind of open that up.

Yes, so the same measures but we put them as called a discussion. Looking for some feedback. I mean, did we, did we get the kind of principles right in terms of how to select measures that suit the purpose that we have in front of us?

And, secondarily, in terms of the process of doing the measure selection and breaking it down into these focus areas, did we get the focus areas right? Is there some area that you think we may be missing here? Because we certainly don't want to miss any measure opportunities. And I will stop there and turn it back over to Sarah to help us out with that.

MS. BROOKS: Thanks, Andy. Yes, and the hands are up, this is great. Let's go back to slide 84 just so people can have reference while we are having this discussion.

Just a friendly reminder for those that we are going, we are going to have comments on, to state your name and affiliation. We will start with Palav.

MEMBER BABARIA: Hi, everyone. Palav Babaria, Department of Health Care Services. So one comment and one question. The comment, which relates to the previous presentation on how we do risk adjustment, especially knowing that there is different mixes of populations, depending on the payer, that we are looking at, as well as the health equity focus area here.

One thing that we have been looking a lot at is how do we think about health equity between Medi-Cal populations and other payers such as those that are commercially insured? We know from our Department's data on COVID-19 vaccine efforts where we have been really tracking countywide vaccination rates versus the same county Medi-Cal vaccination rates, there are huge disparities when we look at measures stratified in that way. So I am really curious, you know. Yes, we need to risk adjust, yes, we know that there are upstream social drivers of health that impact health outcomes, but how do we not do that without losing sight of the ultimate goal, which is to eliminate these disparities between lower income populations that are served, you know, in the Medi-Cal program and commercial populations across the state so that we are really striving for a single standard for our whole state that can be achieved independent of someone's socioeconomic status or other upstream social risk factors? So that is the comment. Really excited to dig into that with this Committee as we move forward.

And then the question is really one thing I didn't see in sort of the guiding principles is how you are thinking about benchmarks and some of these targets? We know that for some measures there are no benchmarks, for some

measures there are benchmarks, but they differ across different lines of business, so the sort of commercial benchmark may be different than the Medicaid benchmark. So would love to hear thoughts of where that fits in as we start to talk about these focus areas.

DR. BASKIN: Palav, you are, you are way ahead of us on that because benchmarks was going to be a discussion probably, probably the next to the last meeting sometime in the summertime. Certainly benchmarks are going to be a concern. We are going to have some information available to this Committee of at least the NCQA Quality Conference results but they are not available to us yet. And it is really premature to discuss those because that is sort of like the second stage of this is selecting the measures and then making some recommendations regarding how to benchmark it and what other benchmarks may be available. So we have a little more research to do on that but it will be --

We thought that we would separate the benchmarking out and the, you know, suggested performance goals, after we selected the measures. But true, we should keep it in mind as we select measures as to, you know, it, you know, how that would happen. And it will be up to, I think, DMHC to understand it. And they know they understand that, that, you know, an MCO organization for a Medi-Cal plan certainly is going to have different results in some measures than a commercial plan, and how they will deal with that I think is still yet to be determined.

MEMBER BABARIA: Thank you.

DR. BASKIN: Thank you.

MS. BROOKS: Ignatius, I am just going to watch if you come off

mute then I'll know you are going to make a comment, so just know I am watching you. All right, Ed.

MEMBER JUHN: Thank you. Ed Juhn, Inland Empire Health Plan. Andy, thanks so much for providing this great overview on how to start thinking about this.

Two questions: When we as a group think about these common focus areas should we also factor into account some form of data completeness threshold, whether it is direct data capture of these focus areas or potentially indirect capture of these data elements; and should we as a Committee prioritize those that may potentially have a higher threshold of available data versus some of these other focus areas that might have a lower data completeness threshold? That is question one.

And question number two is: Is there an opportunity for the Committee to potentially leverage some form of, you know, Delphi scoring approach where we might be able to as a collective group maybe vote after hearing, you know, more about each of these areas through two or three rounds on what the focus areas or the top two or three should be?

DR. BASKIN: Well, so the first question on data thresholds. I mean, you certainly need to account for the fact that is it feasible to do the measurement? That is one of our principles in that is the data even available. Now, hopefully by picking measures that have already had some proven implementation we will have some, we will basically have some knowledge about how well those measures have been able to be reported in the past; and certainly some of the experts on the Committee here would be able to tell us how their experience has been. Certainly IHA and NCQA have experience on the

data collection.

The subset of data which would be whether these measures would be stratified, because not all of them may be amenable to stratification for race and ethnicity or any other stratification that we should recommend. And we certainly know there is going to be some additional challenges as to whether there may be data access to report and measure but there may not be such great data access to report stratifications. And that may be a future, you know, change to the measure set, to add stratification at a later time. But we can discuss that as we discuss each measure because I think it will be a little bit different for each measure. And I forget the last part of your question. I had an answer, though.

MEMBER JUHN: The second question was whether we would, you know, leverage some type of Delphi scoring method or other scoring method as a Committee to kind of go through rounds of how, you know, we may land at the top two or three focus area from this list?

DR. BASKIN: Well, I don't think we are trying to land at a top two, three focus areas, initially. What we are trying to do is say let's pick a focus area. And in fact the first one will be prevention and we may even start it today if we get, have some time, but if we don't that's okay. Where we will kind of see how it works out to say, within prevention how do we get to the first two or -- to the top two or three measures that we would think are worth worthy going on to the final selection process, which will be at the end? Now we may have to take several votes to get to two or three or we may be able to do it, you know, very simply in some of these focus areas to get to two or three.

But then when we get to the end, when we've done all 10 focus

areas, we need to come up with a final set of 10 to 12 total measures. And as I said, we will have more than that and we probably will have to go through several votes to sit and say, how do we start to eliminate some of these measures. And in reality it may be that some of these focus areas no measure survives into the, into the set. Because we somehow have to make that set balanced and work as a set, not just as individual measures.

MEMBER JUHN: Thank you.

MS. BROOKS: Thanks, Ed and Andy.

All right, Anna Lee.

MEMBER AMARNATH: Hi, Anna Lee Amarnath with the Integrated Health Care Association. Thank you, Andy, for your presentation. I just wanted to thank you for pointing out that we will both be focusing on measures that might make sense now but also opportunity to make recommendations for what we might see for the future.

And just really wanted to reflect that I agree with one of your main comments around when we think about measures specifically and how do they fit into the focus areas, many of them across multiple focus areas. Even many the examples you shared as examples within any of these buckets instantly brought to mind for myself, I could put them under four or five of the buckets depending on what we are talking about.

And so I guess one question I might have, based on some of the feedback we have heard from some of the other commenters already is, is there any consideration of instead of focusing on focus areas first but talk more about some of the measure selection criteria. There seems to be some feedback we are hearing already around aspects of the measure selection criteria that people

are wondering about, whether it be benchmarking like Palav brought up.

I'd also kind of point out that we -- I didn't notice any comment around potential unintended negative consequences of certain measures as well, which sometimes is something we want to weigh. And in addition, recognizing Ed's point around the feasibility of measures. So I just wanted to kind of wonder, ask the question of, is there opportunity as the Committee to really go back and talk about what those selection criteria will be and is that something we will be kind of weighing in on? Or is really the direction to sort of start with more on focus areas, knowing that so many measures will cross-pollinate across many of these options that you have here?

DR. BASKIN: Yes. So I don't really, I don't think the intent was to say that these measure selection guidance that we provide today is supposed to be limiting. It is not supposed to say that these are the only things one can consider when selecting a measure, it is just the more prominent ones that we saw in many selection criteria. I mean, for instance, you mentioned, you know, unintended consequences. By all means we expect during this selection that as we talk about these measures that if somebody feels that a measure that has been implemented and there are some known unintended consequences that we should be concerned about, by all means, it should be part of the discussion. So in my mind, I mean, yes, that is part of the principles of selecting measures, we certainly couldn't list everything. But appreciate the fact that there are certainly -- we didn't mean to, we didn't mean to limit the concerns that would be, that are discussable as we, as we start to select measures within each area.

MS. BROOKS: Ignatius, it looks like you might have a comment.

MR. BAU: Yes, I just wanted to also jump in and say, you know,

this is a really difficult task. That, as Andy said, the universe of measures is so vast and large and we don't have a whole lot of time to narrow and so we are proposing this as a process. And I think a lot of what we are going to have to do is, in my mind, do a lot of both, and. And so health equity being an example of looking at some potential health equity measures that are very specific as the ones discussed today by NCQA and by RAND, but then also think about stratification as a strategy across any other measures that we are looking at, particularly around race and ethnicity but also potentially, as NCQA also shared, looking at what the pathway for other types of stratification might be in the future.

And that goes back to Kristine's earlier comment that, again, in those specifications of a measure that we might require race and ethnicity stratification and measurement year one and then add additional stratifications by other demographics in future years would be one way in which the measure wouldn't change but the specifications and the way that it gets reported, collected and reported might change.

And then finally, really emphasizing, you know, back to this constant theme of alignment, is that because DMHC is taking an enforcement approach to this, this is really, we know, just generally, there's lots of room for improvement in quality and, frankly, lots of work that needs to begin in disparities reduction that hasn't taken place in California and nationally. And so really, this is the moment in time in which there is this opportunity to really focus the effort of multiple payers in multiple markets across Medi-Cal and the commercial markets to really focus on what can be improved in the next five years.

That we know there's lots that can be improved but what can we meaningfully move the needle on in a real focused and demonstrated way, both

on quality and to begin on some actual reductions in those inequities, in those disparities in the next couple of years? And that is really how we are trying to think of this funneling process of getting to a set of measures that is reasonable but also will have that kind of impact.

MS. BROOKS: Thank you, Ignatius.

All right; I think I see Kiran's hand up next.

MEMBER SAVAGE-SANGWAN: Thanks, Sarah. And Ignatius' comments are really helpful, I think, at addressing some of my concerns here.

But I will say, you know, I have a question of the way health equity is presented here as one sort of stand-alone focus area and the way that it was described primarily as relating to social needs. Because I think that is an important part of health equity but it is not the only part of health equity so I want to make sure that if we are trying to create a focus area that is about screening for social needs we should just say that and not call it health equity. But to the extent that we are thinking about health equity broadly, well, I want to make sure we are thinking about health equity broadly.

And sort of on that point to the comment about stratification, race, ethnicity, language stratification and where it is possible or not. I think I just want to sort of revisit the discussion from the previous meeting about what role this Committee can have in making some recommendations about how the state improves data completeness and data quality, because I would hate to see us write off the possibility of doing that stratification just because we can't do it right now without taking some active steps to improve it.

And then I also just want to point out that the statute that sort of creates this Committee and this work does call for looking at alternative

approaches, so some of what Ignatius was describing in terms of, you know, there is a lot that hasn't been developed or finalized yet, particularly in disparities reduction. And I understand taking the approach of looking at what is already in use but I do think -- I do think that is somewhat inconsistent with the statute so just want to point that out and see if there is a place in this discussion where we will be looking at some more innovative or emerging practices in quality measurement and disparities reduction.

And then finally, just want to clarify or confirm my understanding that we are looking at one measure set for all of the plans that the DMHC regulates. And I have a question about sort of how that works when we really are thinking very different needs, potentially, in Medi-Cal where, you know, many more births are covered so we would want to look at more birth outcome-related measures versus Covered California, for example. So I just want to understand how the Department is thinking about the differences in the member populations of the plans and how one measure set would apply to all of them?

MS. BROOKS: Kiran, you asked a lot of great questions and made a lot of great comment, thank you.

I see Ignatius' hand is up so let me start with him. No, he is shaking his head no, he is okay.

Andy, did you have any initial quick comments in response to Kiran? And then I think I have a couple of comments after that.

DR. BASKIN: Well, you know, I certainly appreciate the comments and it is challenging, to say the least. I can't speak to the alternatives that, you know, are in the legislation or the regulation and perhaps DMHC can. But to say that, you know, we are on a timeline that requires that there be something that

could be measured, reacted to, or, you know, improvement activities and then some accountability over a period of so many years. And certainly a measure that is not, you know, fully developed at the time we are making the decisions would probably not, practically speaking, be able to meet those needs of DMHC, so that is why we looked at those as areas where we could make some recommendations. But probably, but a measure that is not actually developed today and has been at least used in a situation that we know it is a mature measure and can actually, you know, be reliably utilized wouldn't make any sense.

In terms of the issues that, you know, you think about it, if you get to 10 or 12 measures, you are right, you can't cover everything. There are going to be some gaps in the measurement and there's going to be some areas that some folks are going to be more concerned about than others and we are just going to have to make the hard decisions to say, which are the measures that would be the most impactful and the areas that the state feels that should be focused on. Perhaps the areas where there's more disparities but also areas where there's just more opportunity for just quality of care, with or without the disparities measurement. And I guess I will stop there. I don't know whether DMHC wants to comment at this point or not, I don't want to put them on the spot, but if they do.

MR. NAU: Yes, this is, this is Nathan. Thanks, Andy. A couple of things from me. Like Andy mentioned, we do have a timeline and so final recommendations, according to the statute, or due to us September 30th. That seems far away but, you know, it is -- in reality it is not, given the conversations that we have to have. And these measures would apply to our full service health

plans plus our behavioral health plans. And so some of the discussions that we are going to be having is how do we report these measures, how they stratified. And so for the measures that apply it could by line of business, for example. But we are interested in having those discussions and having some formal recommendations on them. And of course we are open to discussing anything which includes, you know, innovative practices or California-specific measures, we just need to know what the Committee is interested in and that will be represented in those final recommendations.

MS. BROOKS: Thanks, Nathan. All right.

I know that we are getting close on time here; I just want to do a check in terms of where we are at. There are lots of hands up still and we need some more time, just to be clear. So we have another meeting coming up, as you all know, it is on April 20th. So what we are going to do, I think -- we were thinking about taking a vote today. We are not going to do that, we don't believe we are ready for that. I want to make sure everyone has enough time to discuss, ask all the questions they have, before we get there and make any comments that are needed.

I will just ask for one more comment, I think, from Lishaun who had her hand up next, and I see her looking really ready to ask her question so I know it is going to be a great one.

We are going to then take a list. We will follow up with everyone to get your questions so please write them down right now just so that we can make sure we start with those at the beginning of the next meeting and think about how to best respond to them in-between as well if there are ways to do that.

And Nathan, I know you had something to say as well so let me just

see before we turn it over to Lishaun to see if you had any other comments?

MR. NAU: Yes, thanks Sarah. And perhaps we will we will continue to go through the questions until our time ends today. But thank you, everyone, for being so engaged. Given the fact that we have as much feedback as we do, and people who haven't spoken yet, we will continue the baseline discussion next meeting so we will circle back and kind of strategize on how we modify our agenda and our approach going forward. But we appreciate the engagement and we don't want, we want to make sure everyone is heard so we don't want to close off the conversation without them being done yet. So thank you again and we will collect the questions and we will modify our approach moving forward.

MS. BROOKS: All right, thanks, Nathan.

All right, so Lishaun real quick, we will go see what question you might have and then we will move to public comment from there.

MEMBER FRANCIS: Thanks, Sarah. So I guess the biggest thing for me is that I am noticing that none of the focus areas are specific to outcomes. And I don't know if that is because we are not tracking any or we don't have them available, but this is really reflective of some of Kiran's comments about what are we talking about when we talk about health equity, right? Equity in what exactly? Is it equity in outcomes? Is it equity in screening rates? You know, what specifically are we trying to be equitable about and I think that is still not clear to me. So, you know, if it is outcomes then I think we have to measure that. We have to figure out a way to measure outcomes in some way, shape, or form and I haven't heard that or seen that conversation at all.

The other thing is, some of this is about organization and how

about it. I don't know if it is really possible to do the thing that we want to do it just 30 measures, max. But I am looking at this and, you know, I am seeing things like prevention, which I think is really early identification. But there are things that measure or tell us about how the population is doing and then there's things that tell us how system is doing. I think if we are clear about what falls into what. Like access talks about how the system is doing, right? Early identification or prevention is going to tell us how people are doing. And if we are clear about how many measures we want in each of those buckets I think it will be easier for some of us to wrap our heads around, at least certainly me.

DR. BASKIN: Let me just make a brief comment about outcomes. By no means is this restricting the type of measures within each focus area. In other words, there are certainly chronic condition measures, which are process measures, and some that are outcome measures. We certainly can discuss outcome measures and they -- and as we discuss each area. And then there are many who may prefer outcome measures, which is perfectly fine, that often comes up. But in some areas there are no good outcome measures. So we can have those discussions as we go through the available measures in each particular focus area.

But you are right, certain focus areas are not outcome. Like the utilization measures, they are not really, they are not really considered outcome measures per se, at least not in the way you usually think of, you know, does it mean that quality of care occurred, it just means that care did occur. But it very well may be after discussion with this group that utilization measure doesn't make it to the final list because of that reason. So those are very valid points and things that should come up as we discuss the individual measures as to

whether they, you know, meet our threshold or not.

MS. BROOKS: All right, thank you, Andy, and thanks Lishaun.

All right, Shaini, let me just turn it over to you and see if we have any hands up from the public.

MS. RODRIGO: There are no raised hands at this time.

MS. BROOKS: Okay. Well, that gives us a little bit of more time. So, Diana we will just keep going. Leave a few minutes at the end because we do want to close out with a couple of comments about the next meeting and just kind of planning for that. But Diana, let's go with you next then.

MEMBER DOUGLAS: Thank you, appreciate it. Just want to say appreciate all the work into today's presentations from everyone and especially going into the identification of focus areas.

As we start to consider both focus areas and then drill down into measurements one thing I wanted to note is that in so many ways California standards exceed those that are used nationally or those that are common in other states. So while we want to strive towards alignment and consistency I would also urge us to look for ways that the measures we select can capture California's sort of leadership in enacting some stronger standards to protect quality of care and access to care.

And then, and then looking at some of the focus areas. Some, I think, if included would just require stronger demographic data and stratification especially of demographic data. I think patient experience especially comes to mind in that it doesn't always reflect the quality of care or outcomes specifically and it can reflect difficulties of treatment or anxieties over billing, just to name a few. But now coupled with stratification of social and demographic data I think

we could really use those measures to drill down to how experiences differ based on race/ethnicity, or language or SES or SOGI. But I would say that patient experience doesn't always capture the quality or delivery of appropriate care.

So again, this just underscores the point that Kiran made earlier really well and that others have said about making sure that we try to leverage the work of this Committee here in this process to make a real effort to pursue stratification and collection of data related to these characteristics in a way that they can be sort of, you know, mutually support some of the other focus areas or measures we might choose.

MS. BROOKS: Great comments. All right, Doreena.

MEMBER WONG: Yes, thank you, Doreena Wong from ARI. I kind of echo a lot of the comments that were said. Well first let me just give, share a comment about one of the categories that I believe maybe could help reduce the number of focus areas because I believe that behavioral health includes mental health and substance use abuse so that we could put it under behavioral health or else just, you know, have mental health as a separate one from substance abuse, that is just kind of a clarification issue.

But I had just -- and this is also related to -- and yes, I do appreciate all of the presentations today, they provided such helpful information and is a good starting place for us. But it is only a starting place, I think, as Kiran said. You know, that we have to kind of look even beyond maybe what is already there, although I understand the feasibility issue.

But it is related to the data collection and stratification of data, the collection and reporting of data as it, you know, relates to what is available data

and how we can push the envelope on what is available? Because part of the problem for many of the health disparities is that we do not have the disaggregated race and ethnicity data that we need to identify which populations are truly suffering from disparities. We know that, you know, there are so many categories. Just as an example, for some measurements Asians are put together with Native Hawaiian/Pacific Islanders, which is really crazy to put them together in one category. Or even within subpopulations within the Asian category, even within ethnicity, there are just differences because there is so much diversity within those areas.

And so I would like to see kind of the disaggregation of the available data as a core principle of what we do and as a criteria for us to look at what measurements we should prioritize. Because I think if we could lead on the collection and reporting of disaggregated data that would move the whole area of health equity in so many ways. Because you know, the collection and reporting data is so fundamental to identifying and addressing health disparities. So I guess that would be kind of my comment and encouragement about how we should be looking at even these focus areas. It would be helpful, for instance, to know what available data there is in terms of disaggregated data in order to -- well, in order to look at the measurements, certainly, but -- and help us prioritize those measures.

MS. BROOKS: Excellent points, Doreena, and things that I think were great to be said so thank you. All right, so I am looking at the time. Cheryl, do you have a question or a comment? I am just going to ask you.

MEMBER DAMBERG: I have both.

MS. BROOKS: Both, okay.

MEMBER DAMBERG: So do you want to hold it until the next meeting or do you want --

MS. BROOKS: why don't we go ahead but I think you will be the last one. I'm sorry to Kristine and Alice, I apologize, we almost got there, but we will be sure to take you guys first next time. So go ahead, Cheryl.

MEMBER DAMBERG: Sure. I am going to make a couple of comments. When I look at this slide I think about the fact that there are different populations, there are different domains; so some of these represent domains, some of them represent populations. And then there are different types of measures and they can be single measures, like colorectal cancer screening, versus some of these indices. So I think maybe some structuring into those buckets would help and then trying to play out, you know, say within access, you know, what are we really talking about?

So one area comes to mind and I don't know whether this will be the focus of access but, you know, with the COVID-19 pandemic and the huge uptick in the use of telehealth services and, you know, possible continuation of payment policies that will support that use and improve access to different subgroups. I mean, it would seem to me we would want to know something about telehealth use across these different populations.

The one thing I will say having kind of done this work, particularly in the Medicare space, is that this process tends to be iterative in that, you kind of have to look at the data to see what the data will support. I recognize we don't necessarily have all the social risk factor information we want, but even with that information you don't necessarily have the denominators you need to get to reliable estimates.

So I have a larger question as we kind of go down this path of selecting measures is, what kind of data would we have available to help inform selection of measures? You know, whether that is based on literature review and smaller studies that have looked at just differences across subgroups or are we able to leverage any of the California data, whether it is on the Medicaid side, you know, the commercial data, the Medicare data on the street, at least for Medicare Advantage, in terms of the stratification. If we are trying to figure out, you know, where are the kind of sub-performing areas to, you know, try to get to that parsimonious set. So, I think that to me is, you know, I would like to see some data and I don't kind of know what type of data we are going to have access to.

DR. BASKIN: Cheryl, I am going to ask you something because I need to be clear. So the entities that are doing the measurement are actually the MCOs that are going to be reporting; I mean, that is the way this is structured as best as I know. So we will be requiring the MCOs to report; and if we require them to report something we would have to determine whether they have access to data. And it would have to be presumed -- well, depending on what measures we pick, but from what I am hearing, a lot of it would be, you know, member-specific data as opposed to, you know, aggregated population data, although we may choose a measure with some aggregated data.

So I guess I -- I guess we should be thinking about, you know, other than the traditional information data that is available to a managed care organization, if there is some additional information like a data set in California that we could marry that with the information or the MCO can marry that with the information they have supplemented to provide better, you know, results, that is

something that is, you know, fair game we should talk about. But I think at the moment it is restricted to whatever the managed care organization could potentially measure or we think they could potentially measure.

MEMBER DAMBERG: Right. I think I understand that piece of it. But if you are going to go down the path of selecting what measures you want the risk-bearing entity to report on, and we want to, you know, have their focus be on improving equity in certain spaces where, you know, maybe the gaps are the biggest, do we have any information to say, oh yeah, the focus should be on colorectal cancer screening, or it should be on, you know, measuring patient reported outcomes associated with cancer treatment. How are we going to make informed choices about whether the focus should be on, you know, blood pressure control versus, you know, managing diabetes versus immunizations? I think that was my question.

DR. BASKIN: So where does disparity --

MS. BROOKS: And I think -- Andy, real quick, just because I know we are out of time and I apologize. I think that it is important to consider kind of what the -- I hear what you are saying, Cheryl, in terms of there needs to be information to make the decisions, I think is what your kind of overall underlying statement is, and so definitely understand that and didn't mean to cut you off, Andy. I just wanted to make sure I was respectful of people's time. Real quick. It looks like maybe though --

MR. NAU: Hey, Sarah, this is --

MS. BROOKS: -- we have a couple of minutes extra so I maybe just cut us off short. I apologize, Nathan, I just saw your message, I'm sorry.

MR. NAU: That's okay. Maybe if people don't mind we can

actually take the last two questions.

MS. BROOKS: Yes, sure. So we will come back, Cheryl, on your statements, apologize.

Kristine, did you want to go ahead and go? Sorry, I put you on the spot.

MEMBER TOPPE: Yes. I was going to make a suggestion that it would be useful for us to, I think, look at what the existing requirements for health plans are around measures that relate to stratification. So NCQA has requirements, as Rachel shared, for five measures that are stratified. And I think it would be productive knowing that, that that's going to -- that is going to happen for plans. And Covered California and DHCS have their equivalent requirements. And if that could be laid out for the, for the Committee just to see kind of what gaps the, you know, where those measures fit, kind of how they tie to the focus areas, that would be a productive way to start. Because that is a set of five, at least from the NCQA set, as a starter and they cover a lot of different parts of these, excuse me, facets of the focus area. So I just wanted to say that that might be a practical way to kind of see where the baseline is. Thank you.

MS. BROOKS: Thank you, Kristine. All right. And Alice.

MEMBER CHEN: Thank you, guys, for hanging in there. So just one quick share, which is, we are working with National Quality Forum to try to quantify the impact of the four measures that we have selected for our Quality Transformation Initiative, so colorectal cancer screening, blood pressure, diabetes, childhood immunizations, to Cheryl's point of like, do we have data around? Like, is this important? How would it affect our population? So as we move forward with that happy to share that.

And then I apologize if I am repeating what my colleagues shared because I couldn't make the last meeting but I think I would just step back and ask the Committee here, what are we trying to achieve with this? There is the charge that DMHC has but then the Committee, like, we, you know, I think there is a mindset of let's hold health plans accountable, and there is a lot that they need to be held accountable for; and then there is another piece where could we actually use this to improve health and equity in California?

And I will just share our experience with our Quality Transformation Initiative, we are actually tying significant dollars for health plans around a very small number of measures. You know, when Andy and Ignatius talk about parsimonious is 10 to 12, we landed on 4. And partly because in talking to the health plans, that is not that those are the only 4 that are important, but those measures that I just mentioned, people are not doing well in them, COVID has made it worse and there are significant disparities. And what we felt like was if we started even with 10 or 12 or 15 we wouldn't actually see something change on the ground. And even so, we have to do it in conjunction with Medi-Cal and CalPERS so there is an alignment piece in having DMHC really lean in for the entire ecosystem of California is very, very powerful.

I just say, this is a first in the nation. It is also just a first step. We don't have to like boil an entire ocean here. The question is, what can we start with that could potentially make a difference while we are still in our current jobs? Not like 10, 20, 30 years from now.

And I would say, in talking to our managed care plans really I keep, I keep wondering when the other shoe is going to drop and people are going to push really hard against us because a lot of money is at stake. And what people

told us was the reasons that they -- I think besides the fact that people can't in public stand up and say, you know, don't hold us accountable for blood pressure, diabetes, you know, basic cancer screening. They said, it is because you focused. And the truth is, we can't improve on more than a few things at a time. And so thank you for the parsimony and thank you for the alignment.

So I would just ask you, although at least we have been on this journey for probably one or two years now. And if we, if our experience can be helpful in, in this process, we would love to share what we have learned.

MS. BROOKS: Thank you, Alice. All right. Okay, so that got us through the hands for today. I am sure we will have lots more discussion at the next meeting.

This does bring us to the end of this meeting. A friendly reminder that all of the materials are on --

MEMBER CHEN: Sarah?

MS. BROOKS: Yes.

MEMBER CHEN: I really apologize. I had one big note to myself that I, that I meant to say which is, I couldn't agree more with Kiran. Social needs screening is not disparities. And what I would say is, the way we have approached it in QTI is we are planning to stratify by race/ ethnicity all of the measures. So we have four core measures actually plus two behavioral health measures and so happy to share more about -- and I guess, and I am sure you heard some about this last time. But I do think not letting the perfect be the enemy of the good in terms of stratification by race/ethnicity would be an important principle for us collectively.

MS. BROOKS: All right, great, thanks, Alice.

All right. So our next meeting will be on April 20th from 1:00 to 4:00. As we have mentioned previously, the April Committee meeting will be held in-person at the DMHC's downtown office in Sacramento, so we will be moving from full virtual to having an in-person meeting. However, since this commission is an advisory board the Bagley-Keene Act will allow for some Committee members to attend remotely. The primary physical meeting location will be included in the 10 day meeting notice, so that is a requirement and it will be included there. A quorum of the advisory body members must be in attendance at the primary physical meeting location. Advisory body members participating remotely will not count towards establishing a quorum so we will ask all local Committee members to attend in-person to ensure a quorum. I hope that makes sense, that we need a quorum to take a vote and that we need people in-person to take a vote, so we are asking people who are local to come to the meeting. A survey will be sent out at a later date when planning for the April meeting to ensure we have enough Committee members that are able to attend in-person.

And the public is welcome to join us in-person for the meeting starting in April. We will continue to offer the public an opportunity to participate remotely and we will include information about the remote options in the agenda that will be coming out soon.

So thank you to everyone for participating today and we look forward to our future discussions. Thank you, everyone, and have a wonderful day.

(The Committee meeting concluded at 12:08 p.m.)

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I, JOHN COTA, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Equity and Quality Committee meeting and that it was thereafter transcribed.

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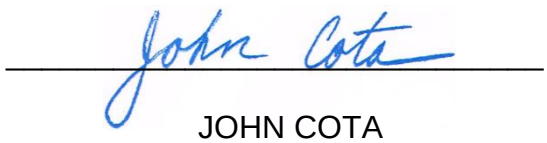

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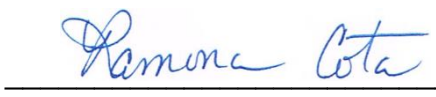

April 4, 2022

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